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# THE MEDICAL JOURNAL OF AUSTRALIA

## EDUCATION NUMBER

VOL. II.—16TH YEAR. SYDNEY, SATURDAY, AUGUST 31, 1929. No. 9.

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By A. MAITLAND GLEDDEN, M.D. (Brussels), F.R.C.S. (Edinburgh), M.R.C.S. (England), L.R.C.P. (London), *Sydney.*

THE newly qualified man may be contemplating starting as a general practitioner in the City of Sydney and after thirty-two years' experience in College Street, I may be able to give some advice as to his taking such a step.

For the purpose of these notes I am taking only the central part of the city, College, Elizabeth, Macquarie and Phillip Streets, and am excluding Camperdown, Darlinghurst, Pyrmont and Surry Hills, regarding these more as suburbs from the point of view of medical practice. Having thus fixed the area of the city, what is the definition of a general practitioner? I take it he is a medical man practising medicine, surgery and midwifery. The old time brass plates had on them "Physician, Surgeon and Accoucheur."

Now, thirty-two years ago there were three surgeons, Dr. (now Sir) Alexander MacCormick, Dr. (now Sir) Charles Clubbe and Dr. T. Fiaschi, three gynæcologists, Dr. Foreman, Dr. Thring and Dr. Worrall, two ophthalmic surgeons, Dr. Evans and Dr. Odillo Maher, one ear, nose and throat specialist, Dr. Brady, one X ray specialist, Dr. Herschell Harris and Sir Philip Sydney Jones, Dr. E. I. Jenkins and Dr. Scot Skirving were consulting physicians. With these exceptions we were all general practitioners. Now specialists in all branches are so numerous that they have their separate sections in the British Medical Association.

*Tempora mutanter et nos mutamus in illis.*

When I started practice in the city in partnership with the late Dr. Pickburn, there were many business people living "over the shop" in George, Pitt, York, Kent and other streets and there were but few doctors in the near by districts of Darlinghurst, Paddington, Woollahra, Waverley, Redfern and the Glebe. With the increase in value of property in the city there are now but few residents and these mostly caretakers. Medical men themselves have moved out and at present there are less than a dozen actually residing in the city and of these about one-third would describe themselves as general practitioners. All the near by suburbs are well supplied with doctors and for this reason and the migration of residents from the city, the area of practice of the city general practitioner has become more and more restricted.

Members of friendly society lodges in the city have decreased in number owing to the same causes.

My advice to any young graduate thinking of general practice in the city is that of *Punch* to those about to take a step in another serious direction—"Don't!"

If he still persists, he must try to get some friendly society lodge work and even if successful in that he must be prepared for a long waiting period. I would say to any young medical practitioner, do your resident hospital appointments, then see something of the outside world, get into general practice in the suburbs or country and if your bent is towards some specialty, equip yourself by post-graduate work and study, but bear in mind that the best specialists are those who have been through the strenuous life of a general practitioner.

## GENERAL PRACTICE IN THE SUBURBS.

By C. H. E. LAWES, M.B., Ch.M. (Sydney), *Petersham, New South Wales.*

GENERAL practice in the suburbs of a great city differs in many ways from practice in a country town and although the main principles are the same, the differences are sufficiently numerous to warrant a separate article on the subject. I have had experience of country as well as suburban practice and therefore am in a position to understand the conditions of both. A few years' practice in the country is an excellent preliminary to suburban work. The experience gained by the practitioner in the country, especially if it follows a resident hospital appointment, stands him in good stead when he settles down in the suburbs.

Having decided to practise in the suburbs of a city, the medical man is at once faced with the problem of how to start. Four methods are open to him: (i) Purchase of a practice as a going concern; (ii) purchase of a partnership; (iii) acceptance of an assistantship with a view to subsequently acquiring an interest in the practice and (iv) "squatting," by which is meant putting up one's plate and awaiting the receipt of custom.

(i) If the practitioner's finances allow of it, I am strongly of opinion that the purchasing of a practice outright as a going concern is the best procedure. It is essential that the incoming man should, for a time at least, live in the same house as his predecessor. Therefore, he must either buy the house or obtain a long lease. Even if he should not like the house, it is important that the practice should be transferred with as little outward change as possible. Patients get used to coming to the same house. Some of them have been doing so to the third and fourth generations over a long period of years and seem to resent a change. In this respect I find that the suburban patient is far more conservative than the country one.

(ii) My experience has led me to the conclusion that medical partnerships as a rule are unsatisfactory. I have not had personal experience of a partnership, but have seen a number of them in operation. Medical practice has a large personal element in it and this often leads to one partner being preferred to the other and a certain amount of friction follows. Then the two partners may be men of totally different dispositions and tempers and these are often not compatible. When there are three or more partners and each partner is allotted his own particular sphere, matters go more smoothly, but as a rule partnerships of two do not

seem to last long. Of course, there are exceptions and I personally know of one or two partnerships of two that have lasted for years. On the whole, however, if a medical man has sufficient means to buy a partnership, he should be able to buy a practice, even if it is a small one and as a rule he will be much happier on his own.

(iii) Acceptance of an assistantship with a view to the subsequent acquisition of an interest in the practice is a good way to make a start for the man who has no money. While he is an assistant, he can as a rule save money and take a better position in a few years. The assistantship, however, has the same disadvantages as the partnership with the added one of inferiority of position. The assistant is a paid servant and the position often becomes irksome. A lot depends, of course, on the character and disposition of the principal.

(iv) The man who "squats" looks round for what he considers a suitable locality, procures a house, puts up his plate and waits for patients. As a rule he has some money saved and is quite prepared to wait and build up a practice gradually. It has always been a debatable point which is the better plan for the man who has some money, to sit down and wait and pay out his money gradually or pay most or all of it out at once and step into a going concern. He has to pay for either method of procedure. Although many men have successfully built up an excellent practice by "squatting," in many cases it is a heart breaking affair which ends in failure. Nobody who has a nervous, "worrying" disposition should start in this way. It is essentially the method for the cheery optimist.

In choosing a suitable locality the medical man should try to find one of the newer suburbs which is not too thickly populated, where there is plenty of spare ground and where buildings are constantly going up. In this type of suburb population will grow rapidly and the doctor's practice will grow with it. If he chooses one of the older suburbs, where nearly every foot of ground is built on and consequently where there is little room for increase of population, the growth of his practice will depend on the number of patients he can get away from his colleagues. This is often a long job and usually an unpleasant one. The question is often asked: "How long should a squatter be prepared to last?" The answer to this query is not an easy one to determine and depends both on the temperament of the medical man concerned and on the extent of his financial resources. Personally, I think if the squatter has not made good in three years, it would be advisable for him to "seek fresh fields and pastures new."

With regard to the purchase price of a suburban practice, this is usually somewhat higher than that for a similar practice in the country. This is because the country practitioner has to put up with many discomforts and disabilities which are absent in the suburbs, and also because the cost of running a suburban practice is usually less than that of a country one. The country practitioner has much longer distances to travel, the roads are rougher and consequently the wear and tear on his car are much greater, the cost of petrol is higher and freight has to be paid on all goods, whether personal or professional, brought from the metropolis. The medical practitioner starting in the suburbs can do so with a much smaller equipment than his colleague in the country. For instance, if he requires a special instrument for an urgent operation and does not possess it, he can either borrow one or go into town and purchase one in half an hour. The country practitioner must be prepared for all emergencies and so must possess himself of a much larger stock of instruments, drugs, antitoxins, sera, vaccines *et cetera* than his suburban *confrère*.

The question of the advisability of accepting lodge appointments will at once confront the newly settled practitioner. In a suburban practice they are a great help from a financial point of view and they also help indirectly in building up a good private practice. Therefore, I think the newcomer should certainly take them on for a time at any rate. In the country lodge work is not such an advantage and in a small town may even be a disadvantage in that it lessens the number of private patients. In the small town every one will want to join the lodge, regardless of income limit.

The suburban practitioner should endeavour to get on the staff of a suburban hospital as near as possible to his place of residence. This he will find to be of greater assistance to him than gaining a position on the staff of a large metropolitan hospital many miles distant. This statement may seem to be heresy to many medical men, but I feel sure it is a correct one, unless the suburban practitioner definitely aspires to become a city consultant in the course of a few years. The time he will be called upon to give in the service of a large hospital seeing outpatients, assisting at operations *et cetera* and the consequent dislocation of his practice in most cases will not be worth while. Usually it will be many years before he is on the full staff. On the other hand, if he is on the staff of a local hospital, his hospital work is close at hand and can be much more easily fitted into his daily routine. His patients are more willing to go into hospital near their own homes and any successful treatment is a matter of local interest and so proves beneficial in an indirect way to the medical attendant. The medical man will also in many cases have far more opportunities of becoming proficient in operative and special medical work in the smaller hospitals. In the larger ones he may have to wait years before he gains similar privileges. And lastly he will find it much easier "to get a bed" for his patient.

The suburban practitioner will find that he will have quite a lot of telephonic communications with the large metropolitan hospitals, the board of health, hospital admission depôt, Bureau of Microbiology *et cetera*. He will find it good policy to keep on good terms with all these institutions. He should always make his requests in courteous terms and not lose his temper if he cannot always get

what he wants. Lest anyone should think this advice superfluous, I can vouch for the fact that many suburban practitioners do not act in the way I have just indicated. It is no good abusing the harassed medical superintendent because he has no bed available. If you treat him courteously, he will be anxious to oblige you on some future occasion. On no account should the practitioner ever send a patient to a metropolitan hospital without first notifying the institution concerned and ascertaining if a bed is available. Room will always be made for a patient in urgent need of treatment, if at all possible, but it is very annoying for the hospital staff to know nothing of the matter until the ambulance is at the door.

The suburban practitioner should not let his equanimity be disturbed by hearing from the friends of a patient admitted to hospital that a junior resident medical officer is of the opinion that the previous treatment and diagnosis are all wrong. Junior resident medical officers are proverbially cocksure and will be general practitioners themselves some day. If any really serious aspersions have been made, the wisest plan is to seek an interview with the medical superintendent of the institution and go into the matter with him.

The suburban practitioner has the great advantage over the country one of having specialists always available to come to his assistance either privately or at hospital. He will be wise if he avails himself of this assistance in any doubtful case or in any case of disease of the eyes or ears. Even if the specialist is not able to do much in the way of a cure, the attendant's position is much strengthened by the specialist's opinion and advice. It is especially important to seek the assistance of the radiologist in any disease or injury affecting bones. In this connexion, I would urge the suburban practitioner in cases when a pathological examination has to be made, to try to educate his patient to go to a private practitioner. Far too many patients are sent to the Board of Health or the public hospital. It will often surprise the practitioner to find how many of his lodge patients can afford one or two guineas for a special pathological report.

With regard to social obligations the suburban practitioner will not be required to undertake nearly so many as his country colleague. In the country one has to be identified with all the activities of the town. I recall with some amusement the fact that when I left the country town where I practised for some years, I was President of the local School of Arts, of the football club and of the tennis club, committee man of the race club and the agricultural society, licensing magistrate and a church warden! It is not at all necessary or advisable for a suburban practitioner to be such a "Pooh Bah" as this.

When he starts practice in the suburbs, he will find himself constantly receiving letters informing him that he has been elected vice-president of some club in nearly every branch of sport. If he accepts these positions, he is in each case expected to forward a donation to the club. My advice is to refuse all except those clubs or institutions in which he is genuinely interested. These refusals, he will find, will do him no harm, as the position is quite different from that in the country town.

While the suburban practitioner can quite legitimately undertake a certain amount of surgery in the course of his practice, he will be wise if he recognizes his own limitations. The interests of the patient must be considered in every case and it is wrong for the practitioner to undertake an operation which he knows in his own heart he is not capable of carrying out satisfactorily. But apart from this point of view, it is bad policy. An unsuccessful or imperfectly performed operation will very often act as a boomerang and hit the operator hard. It is far better from a pure business point of view to hand the actual operation and with it the responsibility over to a specialist. The medical attendant will still be paying many visits after the operation and most patients will feel grateful to him for enlisting the specialist's skilled services and so making every endeavour to bring the case to a successful termination. To put the matter briefly, I would counsel the suburban practitioner not to "bite off more than he can chew." In the country the conditions are quite different and an inexperienced man often has to tackle a big job because there is no one else to do it.

The suburban practitioner has far more opportunities of attending meetings of his local medical society and of his Branch of the British Medical Association than his country colleague and he should avail himself of these opportunities as much as possible. The local medical association or society looks after his interests and the Branch meetings enable him to keep up to date. To my mind this is one of the great advantages which a suburban practice has, and which a country one lacks. Ethical relations with one's neighbours differ in no way in suburban practice from those which obtain in the profession generally. If anything, the suburban practitioner should be more careful to "play the game" strictly, because competition is very keen and among his professional colleagues in the suburbs there are "all sorts and conditions of men" and I might add—women.

The recent graduate often feels somewhat at sea when starting in general practice and if the time could be spared, I think it would be a great advantage if two or more lectures could be given during the final year of a student's course on the art of practice, city, suburban and country.

## GENERAL PRACTICE IN THE COUNTRY.

By HORACE PERN, M.R.C.S. (England), L.R.C.P. (London), *Leongatha, Victoria.*

WHEN the Editor of our journal asked me to write a paper on general practice in the country, I

thanked him for the great honour he had conferred on me, but thought he had set me a hard task.

In the first place, why do we become doctors? I suppose the answer would be as a mode of livelihood, to earn enough money to live, to support a family in reasonable comfort and to give them a start in life. If the answer were the truth and all the truth, the public would reply: at the cost of our suffering and infirmities, which would be the truth and all the truth.

Our standing in the world would be deservedly a poor one, our pride a thing of no account.

During the training we are taught the structures of the body, their anatomy and physiology in health, the alteration which takes place in disease, the cause, course, symptoms and physical signs of disease; how to train our senses to detect them; how to use and interpret the purely scientific aids to diagnosis. We are taught a certain amount of treatment in all its branches, including midwifery and we attend a few patients in labour and see surgery performed by master surgeons.

If the training has left a clear picture in our minds of the whole, it will develope a clear balanced habit of thought, develope our senses, give self-reliance and a knowledge when to call in the scientific specialists to meet our needs. It will have formed a solid foundation on which to build our future life's work and will have fitted us for general practice in the country.

If it has developed the purely scientific side of our minds and taught us that our needs are to be met through the scientific branches and not through our own senses and self-reliance, then it has failed to fit us for general practice in the country.

We see disease in its fully developed or advanced stage. Our text books are written and their teaching and main objects are for examination purposes; therefore disease is divided into more or less water-tight compartments.

There are two types of country practitioners, those who belong to the community and become part and parcel of it; the other especially the younger men who commence because it is cheaper and there is less opposition and they can learn their work and perhaps earn enough money to commence in a bigger centre. If they profit by their opportunities, it is a good training ground. Which type they intend to become, will be the deciding factor in the choice of the locality in which they intend to start. Scope for increase, educational facilities, congenial surroundings, hospital accommodation, all have to be taken into consideration.

The first thing we have to decide is whether we will serve God or Mammon. If we serve God, we find Him a hard task master. He is continually driving us on, spurring us to do better and still better work. He teaches us that men do not find their soul through the flesh pots of Egypt, but through toil, suffering and a continual striving to obtain the unobtainable. If we serve Him, we must find out men's requirements. To do that we must read their inmost thoughts, earn their trust and be keepers of their secrets and at times walk in holy places. Before we can supply them, we must understand them; before we give them, we must have the power to give. If we sympathize, we must have suffered. If we wish to understand death, we must have seen men die and walked ourselves through the valley and shadow of death. We cannot give strength, unless we have it to give. We must learn the meaning of Kipling's lines:

> That under Thee we may possess
> Man's strength to comfort man's distress.

We must be leaders of men and have the qualities of leadership, which include the determination to fight to the last ditch and also much milk of human kindness.

If we serve God, we shall serve the community faithfully. Our work will go on and on improving and our reputation with it.

If we serve Mammon, life will be more or less easy. We may make money and become the popular doctor. Patients may flock in from near and far. We shall become past masters in the art of saying and doing the right thing. We shall know exactly what the patients themselves want to do and shall advise them to do it. But because Mammon is kind and understands the frailties of men and deals kindly with them, we shall never do quite good work.

The only drawback is, we now and then meet a man who serves God and he gives perhaps a look, perhaps says a few dry words and we wonder if after all Mammon is quite worth while.

In arriving at a decision these lines may be useful:

> He who works for fame, oft misses the goal;
> He who works for money, coins his very soul.
> Work for work's sake, and it may be
> Both these things shall be given unto thee.

For the remainder of our lives we gradually learn what a doctor's work is.

We must try to get a clear conception of health and disease. It is hard to give a definition of health. I conclude it is the proper performance of the function of the mind and each structure of the body and disease is some cause which actually interferes with it. For the maintenance of health the mind and each structure must be put to their proper functional use; either lack or improper performance will set up degenerative changes, according to the extent of alteration.

The object of life is still more difficult to define. I conclude the real objective is the formation of character, the perfecting of the soul, the courage to live and love to make it sweet. This gives a working basis for our work. We learn the importance of recognizing any alteration in the function of the mind or body and the need of its immediate rectification, that disease often shows itself first by alteration of function and if we recognize it at this stage, by either removing the cause or assisting Nature to do so, it is frequently easily curable. But if the course is allowed to continue, permanent changes take place which we are unable to alter.

When examining a patient we look into the past, present, future and then decide on a line of treatment. The past will tell us the material with which we have to deal, which has been handed down by our forebears. We consider the test to which that material has been put by illness and how it has responded to those tests and the environment in which the patient is living, whether it is good or bad, if any alteration has taken place in the mind and structures of the body, if so, how much. And we try to find out the cause, whether there is any actual disease which can be detected by its symptoms and physical signs. We learn the importance of routine examination. We look into the future and try to picture what fate has in store.

We are now in a position to treat the patient and that is to meet men's requirements, which may be medical or surgical or what not.

Mr. Baldwin gave in his famous appeal to the nation. He said: "The only hope for the world is for it to learn the following: Trust, love, hope and work."

We must earn the trust of our patients and give them back trust in themselves. We must learn the meaning of love and great love gives all and asks nothing in return, therefore we carry other people's burdens and teach them how to carry their own. If the burden be too great, sometimes with a little judicious advice we can lighten it, sometimes we fear to tread. Then we teach them to take up their work again and in doing it will find their happiness. To those whose burdens we cannot lighten, and to those who are past cure, we can point out the meaning of the line: "My choicest wreaths are always wet with tears" and we can show the beauty in their own lives.

Finally, when seeing a dear old lady off who has borne the heat and burden of the day and is very salt of earth, cut some of your best rose blooms and pin them in and when you see the light come back in her eyes, you will know why God walks in rose gardens.

What to say to a patient, how much to take him into your confidence is extremely difficult, especially to younger men who have not learnt mankind. It is very difficult to make patients understand what has taken you all your life to learn and frequently even then you do not understand it. Personally I tell them less and less, their relatives what is essential and leave a lot unsaid.

Patients have weird ideas and tell you the most extraordinary statements made by some other doctor. I frequently say even if he were hopelessly drunk, he would not have said it.

Loose talking and self-glorification may be good for you so far as your practice goes, but may be very bad for the patient.

I frequently meet hale old ladies about eighty who were told when they were quite young that they had a weak heart and have led a sheltered life all their lives because of that statement. Also telling people that they have high blood pressures and giving them their charts is unwise, even though they love it; the first thing they say to you in a half-awed and half-proud voice: "Oh, I have a blood pressure!" On examination you may find blood pressure a very little above normal and a sound or practically sound vascular system. You also know that raised blood pressure is due to wear and tear, so even if they have a high blood pressure, you question the wisdom of increasing it. The great difficulty is the patients with hopelessly incurable conditions, especially the malignant ones. I am sure it is never wise to let them know unless it is absolutely necessary. If so, it is much more difficult to keep them comfortable and I am certain they suffer more pain.

The universal use of cars, good roads and the telephone have quite altered the country doctor's life. Trips which took you all day, you do now in a few hours. Patients come in much more often to see you, so that travelling is much less. Roads are much improved and there is not the perpetual anxiety of being bogged. Life is much easier, yet it has lost much of its charm. One misses a good pair of horses or a hack for which you have more than a kindly feeling, especially on moonlight nights, in big timber and places where the fairies dwell.

The class of work you meet embraces all the ills man is heir to. The class of work you will undertake depends to a great extent on yourself, on your knowledge of your work, the amount of responsibility you are willing and capable of accepting and the way you can use the material on hand.

I have worked under all conditions. Big areas, a life all day and every day and many nights on the road with no assistance of any kind, in a private hospital badly equipped, badly staffed, with an inefficient and even hostile nurse and in a private hospital well equipped and well staffed. Under the first two conditions it is everlastingly surmounting difficulties, fighting ignorance and silly prejudices. You have to be doctor, nurse and everything that entails. The great difficulty is to teach people that orders are orders. Orders should be given in plain words and they should be quite simple ones and if the case is urgent, they should always be written down.

Midwifery is a constant source of worry and anxiety. The conditions sometimes make you shudder. The last confinement I attended in a private house there were the usual time honoured sacks on the bed with paper over them. I received the placenta in the meat dish. I said to the midwife: "After many years I have reached my limit." I attend no more lying-in patients in private houses. I now attend them all in my private hospital. They are confined in the operating theatre under good conditions. If the theatre is needed for surgery, the bed has simply to be dismantled and removed. If you work in a well run hospital, you can observe what good nursing is and learn the tremendous debt we owe the nurses and how dependent we are on them, also the physiology of rest and repair. To get repair, you must have rest.

Dr. Rothwell Adam was speaking to me about surgery. He said: "You may be the best surgeon in the world, but you will never get good results unless you have good nursing." After the dressing has been put on, the patient is in the nurse's' hands. There can be no doubt the Maker of the universe made man and woman with different physiology, so that the combination of the two should make one perfect whole.

Unfortunately, if history be true, there was a slight rift in the garden of Eden which has never quite healed. The work of the hospital is a combination of the whole staff; there must be the proper atmosphere that through the whole of life is the prerogative of the woman. The hospital should be a place of happiness, comfort, where patients can rest and get well, not to be sick, suffer pain and be generally sorry for themselves. The secret is attention to detail. The colouring of the walls should be a soft shade, pleasant to the eye and not dead white. Notices—"Patients must pay their accounts before leaving"—may be salutary to the bad payers, but supremely annoying to look at every day. The wards should be full of well arranged flowers. Food should be well cooked, nicely served and in plenty. Patients should be encouraged to put on their "glad rags" and make themselves look nice, especially the hard working women from the back blocks who lead useful but drab lives. Make them live in a different land! The maternity patients should not have their babies to look after. The young ones should be taught mothering and all that entails. The babies should be kept in a nursery and brought up in the way they should go. Self-pity and general uselessness can be usually overcome with cheerfulness and a little firmness. One lady thoroughly depressed me. I went to the chemist; I asked him to send a pint bottle with a large label on it and to write on it in large letters: "Smiles to be taken frequently." It did not work, as she was either utterly without humour, or thought mine quite misplaced. You will seldom get growls, if so, a few dry words and one day of what you do not say, usually brings peace. Sleep is most essential. I give veronal and aspirin or veronal alone immediately, if they do not sleep and never see any bad results from it. Pain should be always alleviated, if possible, and as it is Nature's call for rest, it can be usually stopped by procuring rest of the painful part. In seriously ill and shocked patients you learn the absolute necessity of rest which is not procured by rushing round and wanting to do something and putting on a mess of some sort here and there, but by giving them confidence and cheery optimism and by the confidence and optimism of those in attendance. Sleep is absolutely essential and a conservation of every little bit of power.

We come to recognize that a good nurse knows more about nursing than we do and if she tells you politely but quite firmly you are talking nonsense, whatever may be your views on the superiority of the male sex, if you are wise you will not argue.

Lastly, if possible have a well kept garden in which the patients can convalesce.

The much debated question is surgery, whether we should operate or not. Surgery is much higher than making an incision, cutting out something and stitching the wound up again. It requires the mature judgement, the knowledge when and how to operate and exactly what to do; the artist's soul, the artist's touch, the healer's mind, the power of walking with patients and guiding their steps.

I remember discussing one eminent surgeon with another eminent surgeon. He said: "Yes, in his day he was probably the finest craftsman in the world, but he was never a surgeon." We undoubtedly can fulfil all the ideals of surgery.

We can do good work and get good results, but we can never acquire the dexterity and quickness which can only be acquired by constant work. The late war taught one lesson, that was the danger of transport, that the end results of serious injuries depended to a great extent on the mode and distance to be transported. There can be no doubt that in serious injuries, abdominal catastrophes such as ruptured ectopic gestation and perforated appendices, the less the patients are moved and the quicker they are operated on, the better. I think there can be no doubt some operations should be entirely left to surgeons with special knowledge. Each man must be his own judge, as long as he recognizes his motive is pure, that he is accepting the gravest responsibility he can, that he is acting as a high priest and not purely for gain; then, if he fails, as we all at times must fail, he will regret, but knows he failed in high endeavour.

When a woman brings her child and you say: "Little woman! I must operate," and she says: "Must you?" and you reply: "Yes!" even the most thoughtless must know he treads on sacred ground.

We are very liable to become self-centred; we have to work out our own problems; we have to teach ourselves; we do that through our own observations, continually reading other men's thoughts, which entails a tremendous lot of hard work and the liability of coming to false deductions.

It is of really vital importance that we meet and talk over our work, receive other men's knowledge and experience and try to impart our own. The traditions, the necessities, the ideals of our profession all tell us so, yet we like all men seem to obey the laws of the jungle.

The question of fees is a difficult one. The main duty of us country practitioners is to serve the community. In most country districts our patients are chiefly strugglers or fighting an uphill game. From our side our education is an expensive one and entails a lot of labour. It is skilled labour, some very highly skilled and all workmen are entitled to charge according to their skill. It is just that we receive reward for our labour, yet it is impossible to charge for labour done. You alter a patient's whole outlook, alter the whole course of his life and perhaps charge half a guinea, you

operate and save him from certain death and only charge a small fee, which is all out of proportion. The rules of the games seem to be the only safe ones to follow. If you knock a man down, never boot him. If you have a man in your power, never abuse it.

Finally, go straight! If you take these rules into consideration and have a certain amount of common horse sense, you will get a working basis. I hope I have been able to show that our profession is one of which we can be proud; also that we country practitioners have our work to do. We receive little honour as men call honour; we can earn an income, we can never get riches; we can understand and live to the meaning of Kipling's lines:

> Not as a ladder from earth to heaven,
> Not as a witness to any creed,
> But simple service simply given to his own kind
> In their common need.

If we have done that, we have looked after our battalion to the best of our ability and tried to make it an efficient fighting force. I hope we have earned the honour for which no doubt many of us pray, that we be given a soldier's death in the firing line.

## THE PRACTICE OF THE SPECIALIST.

By Garnet R. Halloran, B.Sc., M.D. (Sydney), F.R.C.S. (Edinburgh),
*Sydney.*

A confession of diffidence in complying with a request to write on specialism, a subject so protean in character, is natural. Controversial points there are, which even the profession itself has not been able to solve, and the individual himself can but bow the head to what he believes to be the opinion of the majority in many such matters.

Writing for the practitioner who desires constructive information of practical value, a specialist in one branch obviously would not be competent to speak for men in all branches, except in general terms. Hence such an article must be supplemented by inquiry on certain points from others more qualified to speak. While well aware of the very high standard set by men in the Commonwealth who have never left its shores, one is not so much concerned with exceptional genius as with the average man.

Going abroad to acquire further knowledge and experience in order to specialize is advisable for several reasons. We lack in Australia a systematic post-graduate organization with lectures and demonstrations arranged in a progressive manner throughout the whole year. Our best specialists are the busiest men in their practices, who have not much time to devote to post-graduate teaching. On the other hand, there are centres abroad where the best men do devote a great part of each day throughout the year to organized teaching and they are moderately paid to do so.

If medicine be an international science, the intending specialist should study some of his science abroad in its country of origin. He will have ample opportunity for the rest of his life to study Australian methods if he practises in Australia.

Meanwhile there is in the Commonwealth an evident necessity for a post-graduate organization of high standard, which once established and matured, will in time attract other nationals to our shores. The recognition of this desire is evidenced by the post-graduate courses which are given in Victoria and the formation of a post-graduate committee of the New South Wales Branch of the British Medical Association.

From many sources springs the desire for specialization in the various branches of medicine: ambition in many, the ambition to go further along the road of progress in some favourite branch of medical science, to be able to devote oneself whole heartedly to the pursuit of a problem and to follow it through to finality, if there be any such thing as finality in specialism; the realization that no man can be master of all things, but that according to his ability he may hope to become supreme in a circumscribed area.

The love of learning and the acquisition of technical knowledge to which he had access for years in his training school, awaken the urge in another, an urge the more insistent when, suddenly removed from academic circles in the metropolis, one of such a temperament finds an outlying practice less congenial.

Some there are no doubt with lesser motives and the mistaken but prevalent idea that the practice of a specialty is less arduous and more lucrative. For such as these there is a rude awakening, when having failed to batter down the walls he assailed so lightly, he comes to realize to the full extent the magnitude of his undertaking; for in this arena even the most experienced must stand ruthless criticism. Particularly in his earlier years and I firmly believe also at his zenith, his stage is set not so much before the layman as the profession at large and he perforce must strut before the all discriminating gaze of a body of professional men who, in this country, rightly expect a high standard and are quick to detect technical incompetence, tactless dealing or unethical conduct.

I am old fashioned enough to assert that the time spent in general practice is a very essential preliminary to one's special training. *"La specialité est le degré le plus bas de l'art, lorsqu'elle n'est pas fécondée pas les connaissances générales; elle en est la perfection, lorsqu'elle est le couronnement de la science. Il faut finir au lieu de debuter par elle"* (A. Courty). In general practice he learns the meaning of responsibility, the relationship between the family doctor and his patient, the harm that comes of the tactless word lightly spoken by the specialist, remembering always that the general practitioner should be equally guarded in his utterances.

The letter brought by the patient to the specialist has a new meaning when seen in the light of this experience and he senses the more easily and deals more sympathetically with the difficulties of his colleague in the country. So there comes the time when, having taken stock of the position, the decision to specialize is reached. And here I would warn against anything but a most thorough and prolonged training of an intensive character.

There is only one royal road in this as in other things in life and it demands whole time study, determination and a good deal of money.

Practice should be relinquished entirely, that he might be free to apply himself by day to lectures, hospitals and demonstrations and by night to still more study of an extensive literature.

It is hardly possible to estimate the cost of such a training except in specified instances. Moreover, it will vary considerably whether one selects Europe or the United States of America or both as training grounds. If two years' study is conceded as the very minimum and there are many who think it should be more, then one should be prepared to regard such capital outlay as an investment, knowing that in return therefor he has the right to expect a higher rate of remuneration for a higher degree of skill.

In the various specialties there is much that can be learned in Australia, but there is so much more that can be learned abroad in an organized way that time at this stage is more profitably spent overseas and there the intending specialist's horizon is limited by his command of foreign languages. The average Australian is not a fluent conversationalist in foreign languages and so with the exception of Great Britain, Vienna and North America he finds himself ill equipped to attend the many courses of post-graduate lectures being given in other countries. With a command of English, French and German, however, he has the clinics of Europe at his feet.

For the English speaking student with a diploma of an Australian university, the natural Mecca is London, but Edinburgh and certain English provincial towns also offer attractive post-graduate courses. His diploma being registerable in Great Britain, he is always eligible for a paid resident hospital appointment. He takes an equal footing with the English graduate and if he be adaptable in manner to his environment, I believe at times is even given preference, although he may find that competition is very keen in the larger metropolitan hospitals. But the calls on his limited time are so great as a resident that before taking such a post, he should spend six months at least on the whole time study of his subject.

The Fellowship of Medicine, 1, Wimpole Street, gives much valuable advice to the intending specialist in London. Through the medium of this body he has access to fifty teaching hospitals and the special courses of lectures and demonstrations arranged for the year.

There is no greater incentive to concentrated effort than study for a post-graduate degree and the student should lose no time in consulting the Fellowship of Medicine in this regard. In the effort to acquire such a degree, he should become at least a master of his literature. If practice be but the application of theory, surely a wider knowledge of theory must tend to a wider application thereof in practice, granted always that he has the opportunity later to apply himself to the technicalities so expounded and this opportunity he does and must have in his prolonged resident appointments. Therein lies the difference between the one who, to give an extreme case, starts as and remains a resident always watching his seniors at technical work, but through lack of time for reading, knows little of the evolution of the theory which he sees in application. Yet such theory has been evolving little by little in many languages for many years and he will not learn it all as a resident by watching his seniors in hospital. An architect may as well be ignorant of his foundations as a specialist of his literature. A post-graduate degree should be a hall mark of the practical man who has digested his literature.

The library of the Royal Society of Medicine in London is one of the richest medical treasures in Britain, and Bacon's words, "reading maketh the full man," inspire one to use it, for "to study the phenomena of disease without books is to sail an uncharted sea, while to study books without patients is never to go to sea at all" (Osler).

The choice of a post-graduate degree will naturally depend upon the specialty under consideration and the possession of such a degree may lead to preference when the owner applies for a house appointment. It is a *sine qua non* in an application for an honorary appointment in Great Britain and although it is not yet regarded as essential in Australia, the higher academic qualification is not lightly cast aside in the consideration of honorary appointments in some teaching hospitals, other things being equal.

In seeking a resident hospital appointment there is much to be said in favour of the larger general teaching hospitals with special departments as distinguished from the smaller hospitals devoted to one specialty only. If it be true that specialism narrows a man, then it is wiser as a beginner to work in the broader atmosphere of a special department of the general hospital where continual contact with men in all departments keeps him from thinking always in terms of his own specialty. The narrow confines of the smaller special hospitals would seem in time to cramp his general knowledge, as though one organ of the body could be divorced from another; such a groove is to be avoided at all costs.

To perfect himself in the technicalities of his elected specialty is the goal of the houseman and given the time, patience and enthusiasm, this is always possible to an average man. Perhaps of

equal importance is the atmosphere in which he works, the associations he forms, the friendships made with his seniors and the love of tradition established by some of these older institutions. Here he rubs shoulders with the writers of standard works, the research students of the day, the men who have won international repute in the medical sphere. Such men are not content to be merely the practitioners of established theories; they exhibit original and advanced lines of thought culminating in contributions to the medical literature of no mean worth. Their lives would seem to be devoted to the advancement of their science. They leave behind them a monument to their self-sacrifice and a name handed down through the ages. To the student who has learned to understand such an atmosphere, there is opened up a world of interest in his medical reading, for any publication is doubly interesting if he has established personal touch with the author.

London would seem to present unlimited advantages in this regard to the English-speaking student, although the same applies to European and American cities. He who has access to the meetings of the sections of the Royal Society of Medicine, is fortunate in learning to what a high standard medical discussion can attain; a candidate has much to gain by his election to the fellowship of this society.

Crossing the channel, Vienna is the best organized teaching centre in Europe for the English-speaking students, thanks to the energy of the medical profession of the United States of America. The American Medical Association of Vienna was organized in 1903 for the systematic promotion of international post-graduate study. The association has flourished; thousands of men having availed themselves of the opportunities of post-graduate work available there. It was recently pointed out that 10% of its students were British, most of them from the Dominions.

On arrival in Vienna the student should report to the rooms of the association, address Café Edison, Alserstrasse 9, Vienna VIII, where he will find a full written list of courses available.

The teaching is in English and a knowledge of German is unnecessary, but the linguist has a distinct advantage when handling patients in the clinics. The serious student finds every hour of his day filled with work of an intensive character, which ceases only on Sunday afternoons that he may have respite in the delightful environs of Vienna, a countryside so steeped in romance and antiquity. One should spend a few months in Vienna before seeking an internship.

Again the cost of instruction will vary according to the number of courses pursued by the student, but in any case it is considerably dearer than study in other European centres.

A general average might be made with a minimum of ten pounds and a maximum of forty pounds a month.

Attached to the University of Vienna, the second oldest German-speaking University (1365), the medical school was founded in the fourteenth century. Its general hospital (*Allgemeines Krankenhaus*) is now the largest hospital in Europe. Grouped about it are the many other general and special hospitals, so that the student loses no time daily travelling to and fro as he does in other cities. There are opportunities for appointment to internships or as *Hospitanten* in many of the medical and surgical clinics.

Such opportunities also exist in Budapest, but a few hours' train journey down the Danube.

Berlin offers few advantages to the English-speaking student. Courses are listed in the *Charité, Charitéstrasse,* which are fairly constant and should he be fortunate enough to be attached to an English-speaking professor, he will have ready access to the operating theatres and clinics and should he so desire, he can become attached on payment of a small sum to a clinic pertaining to his own specialty. Here as in other German teaching centres, he will find a ready welcome awaiting him and is always the recipient of extreme courtesy.

Paris, like Berlin, presents many well organized post-graduate centres, very little, however, being offered in English. At the *Salle Béclard* in the *Faculté de Médecine, Rue de l'École de Médecine,* he is given full information by an English-speaking secretary. A few of the professors in *L'Hôpital Lariboissière,* St. Louis and Laennec speak English perfectly. A working knowledge of French, however, is the "open sesame" to a vast amount of organized post-graduate work at very low fees. In addition to the prescribed courses of lectures, the student pays for his regular place in the clinics. As in London and Edinburgh there are regular meetings of the French medical societies which he will attend.

It must not be supposed that the student should pass rapidly through the various capitals mentioned. On the contrary, the beginner might be well advised to leave such an itinerary until such time as he has finished his resident hospital appointments and taken his post-graduate degree in Great Britain. He will then perhaps be in a better position to appreciate all that he sees in a foreign clinic. His sojourn may be made to synchronize with one or more of the international congresses and with the special courses of work arranged by famous men in the smaller cities of Europe. The advantages of such a tour in the last year of his course are incalculable. Here again he establishes personal touch with medical men of international repute and inspiring influence. He learns that no country is paramount in any specialized branch of medicine, all have their advantages from a different point of view, but each vies with the other that knowledge may be a common heritage.

It is natural that the enormous population of the United States of America should provide its

quota of brilliant medical men, capable of founding clinics equal to those of the old world and so the student finds institutions which organization and money have brought to a state of perfection. Moreover, from the teeming population the specialist would seem to be able to find material so abundant that specialism has been "pushed" to a degree which seems incredible on the one hand, but doubtfully wise on the other. The names of Cushing, McKenty, Chevalier Jackson, the late J. B. Murphy and Mayo are sufficient guarantee of the advantages to be gained from such a tour. While it is quite usual to become attached to a certain clinic for a prolonged period, there are advantages also in attending the regular courses and demonstrations arranged for post-graduates. Of these valuable information is to be obtained from the Bureau of Clinical Information, New York Academy of Medicine, Fifth Avenue and 103rd Street, New York City. With this as a starting point the graduate will no doubt roam later to the clinics of those men in other cities whose specialty he intends to practise.

The selection of a place in which to practise in Australia will depend on many factors. The natural desire to remain in contact with an academic centre will attract the majority to the capitals. Should saturation point have been already reached in such a capital, the practitioner must expect progress to be extremely slow. Others either from preference or from a desire to minimize the waiting time, prefer to commence practice in a large country centre.

The waiting time will naturally vary according to many factors, but with an acceptable individual of moderate ability the average time is probably six years in some specialties and as much as ten years in the more conservative branches; during such slack years the golden opportunity presents itself of consolidating his knowledge. A teaching appointment, honorary or otherwise, within a medical school is sought by many, whilst attendance at the metropolitan teaching hospitals keeps him *au fait* with modern advances in his specialty.

For the Australian graduate with a desire for original investigation there can be no better time to pursue a post-graduate degree of his own university. He will find the professors of the various departments of his medical school only too ready to give him practical assistance and whatever the shortcomings of the medical libraries of Australia, the study of the literature is time well spent.

The vexed question of hospital appointments looms always largely on the horizon of the specialist. He should have only one goal in this regard, namely, the seeking of an honorary appointment at the best teaching hospital in his city. Assuming that such honorary appointments are made on the basis of academic qualifications and past hospital appointments, the prospective candidate who has followed such a procedure as is mapped out in the preceding remarks, will have a decidedly strong claim on such appointment and "so it would seem, Adeimantus, that the direction in which education starts a man, will determine his future life" (Plato, "Republic IV").

Hospital service of an honorary nature, arduous and time-consuming though it be, is the inevitable lot of the specialist. Here he has the opportunity of seeing work in the aggregate and of following it through to completion. He has too the pleasure of a life-long association with colleagues whose energies are directed always to the one end, the advancement of their science.

Whether it is wise to engage in more than one hospital appointment is a controversial matter. Perhaps most men have done so in their earlier and waiting years. With time to spare and experience to gain they find dual appointments an outlet for their energies, but with an ever growing private practice the lesser appointments are relinquished. At the moment of writing applicants for honorary appointments to the staff of the Royal Prince Alfred Hospital, Sydney, must signify their intention of engaging in the one appointment only, but other hospitals have so far not followed this course. From a financial consideration the well-to-do patient is catered for in the private hospitals or nursing homes of one's choice. Once appointed to an honorary staff, the specialist is able to dispose of those in indigent circumstances to the special department of his hospital and there to treat and follow up the patient.

The disposal of the intermediate class of patient, however, is again a controversial matter. Of these some must enter a public hospital, paying their way in the general wards of the hospital. By virtue of his honorary appointment the specialist is not empowered to accept fees for his services rendered, although many patients offer small fees. The advent of intermediate beds would seem to be long overdue, more especially as the suspicion of public hospital abuse still exists.

The cost of running a specialist's practice will vary very greatly according to the nature of such practice. Leaving out of account heavy expenditure, such as is necessary to equip the radiologist, for instance, the man with a moderate practice spends more than does the general practitioner. In addition to the rental of his suburban home he may begin by sharing his consulting rooms in the city, but as his practice grows the nature of his work may compel him to rent a consulting suite in the city. A secretary becomes essential and perhaps a waiting-room attendant as well. Otherwise, of course, with exceptions, his outgoings will be similar to those of the general practitioner.

Perhaps only a department of income tax could give a clue to the gross incomes derived from a specialist's practice! There is perhaps no subject on which a body of men is more reticent than this. Moreover, an income in this as in other forms of medical practice must vary in accordance with many factors. Should saturation point not have been reached in a certain specialty, then the law

of supply and demand will surely see that such point is not far distant. The average income of each man engaged in this specialty must then drop. Should another specialty appear more lucratitve, it will then be assailed until it in turn becomes less attractive.

Of the plethora of post-war medical graduates, some of whom could find no room in general practice, it was natural that some should be attracted to the specialties. One specialty in the State of New South Wales which in 1914 supported ten men, now supports thirty, but that State has not trebled in population. Other specialties tell a similar story. The position I firmly believe at the present day is that a great many are content to earn a modest competence. Others are content to supplement by special practice a preexisting private income. Few do any better than if engaged in other branches of medicine.

Some senior men who count themselves successful, probably are able to live as well as those in the first flight of other professions, such as the law. There are a few brilliant outstanding examples who reach higher figures. Much will depend on whether he practises, Midas-like, purely for the purpose of making money or whether independent of such an income he practises as a hobby, for a few such there are, "counting themselves rich in the treasures of widened experience and a fuller knowledge of men and manners which contact with the bright minds in the profession insures."

Much of his success may depend on his beginnings in practice, his ready acceptance or otherwise by the more senior medical brethren and his older professional friends, the paying of the not unimportant courtesy call and the taking or denying himself an advantage in practice at the expense of a colleague-to-be.

No matter how circumspect the newcomer, it is probable here as in other spheres that he may encounter petty jealousy as he advances. And for such he will make due allowances, remembering that "Success breeds Envy, Envy breeds Hatred."

Working in constant contact with seniors whose methods he respects, it is inevitable that as the years go by his individuality becomes cramped. The junior naturally looks up to the opinions of the more experienced man and in the rush of work it becomes in course of time the line of least resistance to adopt them. Or again success may at times be accompanied by a restful satisfaction, a satisfaction that may initiate his insidious decline. For such there is no better antidote than a trip abroad, once more to the clinics in which with maturer experience he now sees newer methods and instrumentation and absorbs the enthusiasm of other continents. It has been said by those who need not count the cost, that such a tour should be undertaken by the specialist every five years and undoubtedly it makes for a higher standard of practice. Those so fortunately endowed must have risen high in their profession and at the end of such careers one is justified in asking what have they given to the progressive evolution of their specialty that their names will survive after them. While few may aspire to a niche with those glorious medical names of the past centuries, there is already in Australia a steadily growing record of original research worthy of countries with institutions more richly endowed.

To the specialist just embarking on such a career there can be no greater incentive than *"faber suæ quisque fortunæ est."*

## FRIENDLY SOCIETY LODGE PRACTICE.

By D. ROSENBERG, M.B., B.S. (Melbourne),
*Melbourne.*

THE fact that 25% of the population of Australia secures medical attention through the organization of friendly societies shows how great a hold this system has on the medical work of the profession. It used to be an appendage of practice. Years ago it was a system by means of which a medical man could allow those of his patients who were unable to pay his ordinary private fees, to pay him a smaller amount per medium of the lodge. It was considered if not sometimes by the patient, at least by the doctor, that the small amount received from each patient was a concession to the less wealthy of his clients, a good system which removed the stigma of charity and enabled his patients to feel that they were under little or no obligation to their medical adviser. It was not long, however, before the system became abused. As the members of lodges became wealthier, they still retained their membership in the lodges and secured their medical attendance at the same rate as formerly. In some States budding politicians used the friendly societies as stepping stones to the local municipal council, even to the ranks of the legislature and many a lodge doctor has still to attend highly paid members of parliament as a result of this form of lodge abuse. So popular did this cheap medical service become that in some districts lodge work became the main part of a doctor's income. It was only after many patient years that the profession rebelled against the conditions of friendly society contract practice. The standard of living among all the other members of the community had improved, hours of work had been reduced and the remuneration for work had been increased, yet the hours of the lodge doctor were not curtailed and the remuneration in this State of Victoria at least has not been increased for over forty years. As a result of disputes with the lodges, the conditions of lodge practice have been improved, but great changes must take place before the medical service can be wholly satisfactory.

From time to time politicians, both medical and the other kind, are wont to wax rhetorical on the subject of preventive medicine and to invoke the

help of the general practitioner in their campaign. Over one-half of the fourteen hundred medical men in Victoria hold lodge appointments and probably the same proportion holds good in the other States, so that it may be said that as far as the industrial and the majority of residential districts are concerned, the lodge doctor is the general practitioner of Australia. It is well to examine the conditions under which he works, how far the service that he is able to render, makes for the communal good and to enable him to devote the major part of his time in preventing disease.

In all the Australian States there is an elaborate agreement signed by the medical officer and the lodges and the clauses are uniform in each State, though there is great variety in these matters as compared between State and State. Copies of these conditions are obtainable through the secretaries of the Branches. Attempts are being made to promote a uniform agreement throughout Australia on the lines of the New South Wales Common Form of Agreement. Not one of the present agreements is ideal and all fall far short of what would give to the public an adequate medical service. It has been my good fortune to see how contract practice is operating in Great Britain, Germany and Austria and one must be struck at once with the good quality of contract practice in this country as compared with that abroad, notwithstanding the disabilities of distance and lack of opportunity of post-graduate facilities.

### Income.

The work, however, is poorly remunerated. For attendance on a whole family (average 2·5 persons per lodge member) the lodge doctor is paid capitation fees varying in the city from one pound (Victoria) to one pound ten shillings (Brisbane). Experience in the city shows that if the average doctor has five hundred members on his list, he is working very hard, has crowded waiting rooms and has difficulty in getting any leisure. Some men, with greater capacity for work, are able to take more names on their lists, but when the number given is doubled or trebled, it is rare to see them at Branch or clinical meetings, at the post-graduate lectures given by the British Medical Association or even at local meetings of their fellows. They are always too busy. The lodges have claimed that the capitation fee is a retaining fee which enables the lodge doctors to obtain what they term "extras." A great change, however, has come over the profession in the last twenty years, gradually accelerating during the past ten years. The great bulk of "extras" has been cut down to a vanishing point.

The mind of the public has been diverted to its charitable and philanthropic institutions and away from the conditions of private practice. Enormous sums are being subscribed to the charitable hospitals for new buildings, apparatus and radium. *Pari passu* with this great movement, the profession has increasingly shown its desire to work in conjunction with these institutions for no remuneration whatsoever. A hospital committee has only to advertise an appointment and is immediately flattered by the rush of applicants displaying their qualifications. Only a few years ago the hospitals were for the indigent sick. They next asked the patients to pay what they could afford. Now we are told that hospitals are for the sick. The stigma of charity being removed from the hospital, there is no reason why a lodge patient should pay for "extras" to his medical officer.

For the same reason, too, lodges are losing their appeal to the public and the numbers of lodge members are not increasing as they should. It used to be considered that confinements in a lodge practice were always attended by the lodge doctors. As a matter of fact the *Maternity Allowance Act* was passed to give to every mother five pounds on the birth of her child, the idea being that she should be able to secure proper medical attendance at this most critical period of her life. Statistics reveal a vast diminution in the number of confinements attended by lodge doctors. Lodge patients are being attended at the various charitable maternity hospitals. These are appealing for funds for extensions, advocating the repeal of the *Maternity Allowance Act* to enable the Government to give them sums of money as a wiser method of expending public funds. In the metropolis, especially in the industrial districts, there is an organization for attending women in their own homes with a nurse and a student. Its figures are ever on the increase. The result of this system is that a lodge doctor is introduced to the new baby at the age of three weeks and he attends it until it reaches the age of sixteen or eighteen years at the former capitation fee. Minor operations under an anæsthetic (local or general) are paid for. At one public hospital recently twenty operations for adenoids and tonsils were performed in one afternoon by an honorary medical officer who is finding it difficult to obtain consultation work outside. This particular form of minor operation is an "extra," but lodge doctors with one thousand members on their list have told me that, whereas they used to perform at least one tonsillectomy every week, they rarely do one in a month. The same diminution is noticed in regard to major surgery, even in those practices of lodge doctors who are specially qualified. In some States a doctor is entitled to charge for fractures and dislocations, but in this State he has to treat them for the twenty shillings per year. In order that he should give of his best for these conditions or perhaps to avoid legal consequences, he may instal an X ray plant, but should he live in Victoria he cannot charge for the X ray diagnosis or for the treatment if he instals a diathermy machine. Some medical officers in their attempt to keep in contact with modern practices have acquired a cystoscope and the like or have become proficient in the use of a microscope. Should they attempt to obtain a fee for such special service, they will be refused. Recently a lodge doctor sent in an

account for the modern injection treatment of varicose veins and the lodge patient declined to pay it. He reported the matter to his lodge which referred it to the grand lodge. The case came before the Victorian Branch Council of the British Medical Association and under the terms of the agreement we had to disallow it. In this regard the other States are more fortunate, a clause, "payment for special services," being inserted. The standard of medical service required by the lodges themselves shows no advance on that of the inception of lodge practice. Apparently all that the directors of the lodges require is "a bottle of medicine and a sick certificate" for their members.

There are no facilities for consultation. In some States it is possible to refer a patient to a specialist who is attached to the lodge, for special work in eye, ear, nose and throat, but except for a spasmodic attempt by one lodge to appoint a radiologist and dermatologist (the one man to hold both appointments), there is no attempt to furnish specialists for the lodge members. The result is that in most cases where a special investigation has to be carried out, the lodge patient must be sent to a specialist at his own expense or if that is not possible, he must go to a public hospital.

It seems only reasonable that a huge organization which controls medical service of over 1,000,000 persons, should provide adequate hospital accommodation with a medical and surgical service and sanatoria, as is done in Germany and Austria, but there is no such provision in this country. Neither is there provision for obtaining pathological investigation, or nursing, massage, or electrotherapeutic facilities in connexion with the lodge service. Notwithstanding the limitations within which the friendly society doctor labours, it is remarkable how he has settled down to give an extraordinary amount of work.

The lodges have established large pharmacies in many centres where, when it is ordered by the lodge doctor, the members can obtain the "trivialities" of medical requisites in addition to the substances ordinarily prescribed. Rather than argue, the medical officers have drifted into a custom of ordering, when the patients ask, fragments of cotton wool, a bandage, castor oil, boracic acid *et cetera*. In industrial districts, where a lodge doctor must attend at least in his surgery 40% of his patients after his evening meal, such drudgery must be reckoned with.

### Medical Institutes.

In the larger country centres and in the metropolis, the friendly societies have formed what are known as medical institutes. At these medical men are employed at a salary which usually works out at less than the above mentioned rates per lodge member. In their desire to deal what they consider fairly with the medical officer so employed, they give him a schedule under which he is allowed to charge as follows. I quote from such a schedule now before me.

Fee not to exceed £4 4s.:

1. All abdominal operations, including hernias, requiring the opening of the abdominal cavity,
2. All operations on the chest,
3. All operations on the bladder,
4. Removal of varicose veins,
5. All operations of the womb, except passing of uterine sound, applications of caustics, rectifying displacements by pessaries or supports or other minor operations,
6. Curetting,
7. All operations of the brain,
8. Operations for hydatids,
9. All plastic operations for repair of injuries or deformities,
10. Operations for cancer,
11. Removal of piles,
12. Operations on bones,
13. Operations for tumours,
14. Strangulated hernia and all operations of emergency,
15. All operations on the testicles,

Fee not to exceed £1 1s.:

16. Post-nasal growths,

and so on.

Before any medical man applies for such a position, be the total salary ever so tempting, it is advisable that he should communicate with the local secretary of the British Medical Association in the State where he contemplates residing. These addresses are to be found in the Important Notice in THE MEDICAL JOURNAL OF AUSTRALIA.

From time to time medical men have made the mistake of accepting these appointments in ignorance and have ultimately resigned them. Their experience in the institutes has not been happy.

Lodge practice could be made the most useful medium of preventive medicine in the community if the managers of the system could bring themselves to the mental state that admitted that the lodge doctor must be provided with an income and hours of work sufficient to provide time for study and leisure; he must be placed in a position in which he would be able to obtain all facilities of modern medical knowledge and in turn place them at the disposal of the lodge patients long before the time that the hospital receives them.

Too much thought and money have been given to the curative side of medicine, not enough to the domiciliary service, that part of our work that should diagnose the incipient phthisis, high blood pressure, cardiac conditions, diabetes or malignant disease, long before the elaborate machinery of hospitals and sanatoria is required for their cure.

Properly managed the lodge system in Australia should have been a potent force in providing a national service of preventive and curative medicine. It should have given its members a system whereby every ailment would be investigated by every method known to medical science. Instead it has provided practically nothing except a twenty-four hour medical service. It is difficult to see how a truly national scheme of preventive and curative medicine can be established without some measure of compulsory insurance. Such a scheme could be made very efficient, provided that proper safeguards be instituted to prevent the present defects of the lodge system. A complete reconstruc-

tion of the medical service would be required with all the aids that make for efficiency. To build on the present defective foundations in imitation perhaps of the European model would be fatal.

## Friendly Society Lodge Contracts.

THE conditions governing friendly society lodge practice in the several States have varied greatly for many years. Five years ago we published in parallel columns the clauses of the six forms of agreement from which it was evident that the endeavours of the Branches of the British Medical Association to obtain uniformly good conditions had not met with success. In April, 1927, the Federal Committee approved a model form of agreement which had been drawn up at the request of the Queensland Branch and submitted to all the Branches for consideration and comment. We reproduce this model agreement in its amended form. It is the desire of the Federal Committee that the Branches should endeavour to obtain conditions not less favourable than those included in the model agreement.

MEMORANDUM OF AGREEMENT made this day of 19 between (*name in full of Medical Officer*) of (*place of residence*) in the State of (hereinafter called the Medical Officer) of the one part, and (*names in full of Trustees*) of (*place where Trustees reside*) in the said State the duly appointed Trustees of the (*full name and number of Lodge and name of Society or Order*) at present meeting at (*place where Lodge meets*) (hereinafter called the Trustees) of the other part.

WHEREBY IT IS AGREED THAT

1. The said shall be Medical Officer of the said Lodge for a term of months commencing on the day of 19 , and shall continue thereafter to hold such office until the Agreement terminates, either party being at liberty to determine the same after the said date by giving to the other three months' notice in writing.

2. The Medical Officer shall, except as provided in Clause 21 hereof, upon payment to him of a fee of two shillings and sixpence examine every person seeking to become entitled to any of the benefits of the said Lodge, who shall bring to him a statement in writing signed by the Secretary of the said Lodge notifying that such person, if passed by the Medical Officer, is entitled to such benefits, and in the case of any person seeking to become entitled to the medical benefits of the said Lodge, such statement shall certify that such person is entitled, if passed by the Medical Officer, to the medical benefit of the said Lodge, according to the terms of this Agreement, provided that such fee of two shillings and sixpence as aforesaid shall not be payable in respect of any such person under the age of sixteen years.

3. The Medical Officer shall reject every person so examined who, in his opinion, is not of sound constitution and in good health.

4. The Medical Officer shall furnish the said Lodge with a certificate of each and every such examination on a form to be supplied to him by the Lodge.

5. The Medical Officer shall give medical attendance during the continuance of this Agreement to any member of the said Lodge entitled to such attendance by the provisions of this Agreement whose name is on the quarterly list delivered to him by the Secretary of the said Lodge as hereinafter provided in all cases of illness or injury, provided that such illness or injury be not occasioned by any misconduct, drunkenness, immorality, or a disease contracted before the member's admission to the said Lodge, information of which had been withheld from the Medical Officer at the time of the examination, or by the negligent act or omission of any person or corporation by reason whereof such member is entitled to claim compensation or damages in a Court of Law; provided also that the Medical Officer shall be required to attend as aforesaid such members only as pay continuously for the medical benefit of the Lodge from quarter to quarter. In the event of any member ceasing at any time to pay quarterly as aforesaid, his name shall not be put on the Medical Officer's list until he has been re-examined and passed by the Medical Officer, if such re-examination be demanded by the Medical Officer. There shall be a fee of three shillings and sixpence payable to the Medical Officer for such re-examination, whether the member passes or not. The aforesaid list of members to be attended by the Medical Officer shall be delivered to him quarterly, and no name shall be added to or removed from the list during any quarter provided that, in the case of a member examined and passed by the Medical Officer during the currency of a quarter, his name shall be added to such list forthwith and payment in respect of such member shall be made to the Medical Officer as from the commencement of the month following the examination.

6. All members requiring medical attendance who are physically able so to do shall visit the Medical Officer at his consulting rooms during his consulting hours there, that is to say, on (*day of half-holiday*) from to a.m., and to p.m., on (*day of evening off*) from to a.m. and to p.m., on other days from to a.m., and to p.m., and to p.m.; provided that, on Sundays and Public Holidays there shall be no consulting hours, but urgent cases shall be attended to.

7. The Medical Officer shall visit any member not physically able to attend at his consulting rooms if a written message requiring him so to do shall have been delivered at his residence before a.m., stating the name and address, the name of the Lodge, and if possible, the nature of the illness or injury. In a case of urgency in which it is not possible for such written message to be delivered before a.m., as aforesaid, it may be delivered later, but must be marked conspicuously with the word "urgent."

8. The Medical Officer shall give, free of charge, such certificates as may be required by the Lodge for its own use. Other certificates shall be paid for as per arrangement between the member and the Medical Officer.

9. The Medical Officer shall, except as hereinafter otherwise provided, be paid and shall accept payment for such attendance as aforesaid at the rate of per member *per annum* according to the list provided by the Secretary of the said Lodge, such payment to be made to the Medical Officer by equal quarterly instalments on the days fixed by Clause 27 hereof.*

10. The Medical Officer shall attend, if required, the wives of members in their confinement, and the fee for such attendance, which shall include pre-natal supervision, shall be £5 5s. and shall be due and payable at the time of the confinement. In any case in which such attendance by the Medical Officer shall not have been required as aforesaid, any attendance by the Medical Officer upon the mother during the first thirty days following the confinement in any illness arising therefrom, or upon the infant during the same period, shall be paid for by the member at the fees payable in private practice in the same way as if the member were for the time being not entitled to receive the medical benefit of the Lodge.

11. The Medical Officer shall attend, if required, the wives of members in cases of premature birth or miscarriage for a fee of £5 5s., which shall be due and payable at the time of the attendance.

12. The Medical Officer shall meet in consultation when so required other legally qualified Medical Practitioners; provided that he shall not be required to meet any Medical Practitioner who is ineligible for membership of the British Medical Association. When it is arranged between

* [NOTE.—When the income limit, in accordance with which admission to the medical benefit of the Lodge is regulated under this Agreement, is £312 *per annum*, the rate for attendance, (*a*) where the Lodge meets in the Metropolitan Area, is 30s. per member *per annum*, (*b*) where the Lodge meets elsewhere, is per member *per annum*.]

the Medical Officer and a member that the services of another Medical Practitioner shall be obtained for the assistance of the Medical Officer, either by way of consultation or otherwise, the member shall pay for such services at the time of the rendering of the same. And, when the Medical Officer is required as aforesaid to meet another legally qualified Medical Practitioner in consultation, a fee of 10s. 6d. shall be due and payable by the member to the Medical Officer at the time of the consultation.

13. The Medical Officer shall, when necessary, administer anæsthetics, payment for which shall be as per arrangement between the member and the Medical Officer.

14. The Medical Officer shall, when required, attend members in cases of fractures and dislocations, payment for which shall be as per arrangement between the member and the Medical Officer.

15. The Medical Officer shall, when required, give special services, payment for which shall be as per arrangement between the member and the Medical Officer.

16. In any case in which the Medical Officer shall visit a member as hereinbefore provided, at a place more than two miles from his residence, mileage shall be payable at the rate of 5s. per mile for every mile or fraction thereof beyond such two miles travelled on the outward journey in the day time, and 7s. 6d. per mile or fraction thereof so travelled in the night time. For the purpose of this Agreement night time shall be from 6 p.m. to 8 a.m. Such mileage shall be payable at the time of each visit whether the same be made in connection with illness, injury, confinement, or attendance for any other purpose.

17. When any surgical operation, other than a minor surgical operation not requiring an anæsthetic, is performed it shall be paid for by the member, and the fee for such shall be a matter for private arrangement between the member and the operating surgeon.

18. Except in cases of confinement, premature birth, or miscarriage, any member who requests the attendance of the Medical Officer between 6 p.m. and 8 a.m., shall pay to him a special fee of 5s. for such attendance, provided that such fee of 5s. shall not be payable in any case where mileage is paid.

19. When a member who has been examined and passed as hereinbefore mentioned is admitted to the medical benefit of the Lodge, his name shall be placed forthwith on the list of the Medical Officer examining him, and shall not be removed from such list for a period of three months from the date of the examination.

20. No member shall be transferred to a Lodge of the same or of another Order or Society in another place so as to be entitled to the medical benefit thereof, unless he comes to such place as a *bona fide* resident, that is to say, with the intention of residing there for at least twelve months, or unless he comes to reside with the object of following his usual avocation.

21. No member shall be entitled to the services of the Medical Officer in his capacity as such under the terms of this Agreement, unless his name is on the current list, furnished as aforesaid, by the Secretary of the Lodge.

22. The Medical Officer shall not be under any obligation to attend for any purpose any member who is in arrears with the payment of any moneys payable under this Agreement.

23. Except where otherwise provided, all fees shall be payable before the end of the current quarter and the Trustees shall assist the Medical Officer in collecting any such fees and any moneys payable for mileage or for any attendance, provided that a statement in writing of such moneys shall be submitted to the Trustees at or about the end of the month in which the same became payable.

24. The following members only of the said Lodge shall be entitled to the benefit of the medical attendance to be given pursuant to the provisions of this Agreement:

(*a*) Any member of the Lodge who was a member thereof before the day of , 19 , and .

(*b*) Any member of the said Lodge who shall have joined the same after the said day of , 19 , and whose income, including, if married, that of his wife, did not exceed £312 *per annum* at the time of his so joining, and such member shall continue to be so entitled so long as such income does not exceed £416 *per annum*.

Provided that any member joining the said Lodge on or after the aforesaid day of , 19 , whose income, including, if married, that of his wife, does not exceed £312 *per annum* shall be entitled to be so attended whether or not his income as aforesaid, at the time of so joining exceeded £312 *per annum;* provided also that, notwithstanding that a member has income including, if married, that of his wife, as aforesaid, exceeding £312 or £416 *per annum* as the case may be, such member shall nevertheless be entitled to be so attended by the Medical Officer, if, by reason of having many persons dependent on him, he is, in fact, in poor circumstances, and unable, otherwise than through the medical benefit of the Lodge to provide medical attendance for himself and those dependent on him.

25. The medical attendance to be given to a member under the terms of this Agreement shall also extend and be given to:

(*a*) The widow of a deceased member and his children up to the age of sixteen years, if paying full rates, and

(*b*) To the following relatives or dependants of the member:

(i) Wife; if examined and passed by the Medical Officer.

(ii) Children, step-children, and legally adopted children up to the age of 16 years; if passed, with or without examination, by the Medical Officer.

(iii) Widowed mother of an unmarried member; if resident with and wholly dependent upon him, and if passed, with or without examination, by the Medical Officer.

(iv) One unmarried daughter over the age of 16 years of a widowed member, residing with and wholly dependent upon him; if permanently acting as his housekeeper, and if passed, with or without examination, by the Medical Officer.

(v) Brothers and sisters of an unmarried member up to the age of 16 years, both of whose parents are dead; if residing with and wholly dependent upon him, and if passed, with or without examination, by the Medical Officer.

26. A member of any other Lodge of the said Society or Order or of any other Society or Order desiring to be attended by the said Medical Officer under this Agreement as a medical member of the Lodge shall be entitled to be so attended on production of a certificate from the Secretary of such Lodge stating that, if resident within the area of such Lodge such member would be entitled to the medical benefit thereof, and that such medical benefit is regulated in accordance with provisions approved by the British Medical Association in respect of income. No such member of any other Lodge as aforesaid shall be entitled to be so attended, if such Lodge is a Branch of an Order or Society to which members of the British Medical Association decline to give their services as Medical Officers.

27. In consideration of the several agreements on the part of the Medical Officer hereinbefore contained the said Trustees hereby agree to pay to the Medical Officer on the day of the months of and in each year during the continuance of this Agreement or within fourteen days thereafter all such sums of money as shall on such respective quarterly days be due and payable to the Medical Officer under the terms of this Agreement.

## National Health Insurance.

FROM time to time the medical profession in Australia is asked by a few of its members to adopt a definite policy in regard to national health insurance on the ground that both political parties are

committed to the proposal to introduce some form of insurance. It would seem that many members of the medical profession have forgotten that the Federal Committee of the British Medical Association in Australia has already considered this question and on the authority of the several Branches has defined its position. In view of the importance to the whole medical profession of this matter, it has been deemed advisable to recapitulate the facts in this place.

Late in 1923 a Royal Commission was appointed for the purpose of inquiring into and reporting upon national insurance as a means of making provision for casual sickness, permanent invalidity, old age and unemployment, upon the operation of the maternity allowance system and upon the question of amending the *Invalid and Old-Age Pensions Act*, so as to provide for the payment of destitute allowances. The commissioners sought evidence in very many quarters and gathered a great mass of information, much of which must be regarded as of vital importance to the welfare of the people of Australia. The medical profession was asked to express its views through the Federal Committee. After a scheme had been submitted to the Branches, the Federal Committee embodied the amendments that were endorsed by the majority of the representatives of the several Branches and forwarded the scheme as the opinion of the medical profession to the Royal Commission. The scheme is as follows:

That a Commonwealth Health Insurance Department be established under the Minister of Health to effect the insurance of all persons with income below a prescribed amount against accident and all sickness (on lines somewhat similar to those adopted in recognized accident and sickness insurance by insurance companies), with the proviso that in the administration of the insurance, the practising medical profession be adequately represented by nominees of the medical profession.

If such a basis is to be suitable it is thought that the term "all sickness" should be interpreted literally and should include tuberculosis, alcoholic and venereal diseases and malignant disease.

That the beneficiaries shall be insured against the cost of medical attendance and have free choice of medical attendant from among those practitioners who undertake insurance practice under the system.

The scheme shall include:

(*a*) Treatment by medical specialists who are legally qualified medical practitioners, registered in the State in which they practise.

(*b*) Institutional treatment (medical, surgical, mental, tuberculosis, malignant diseases, venereal diseases *et cetera*), provided that facilities are maintained for medical education and research.

(*c*) Special treatments.

(*d*) X ray, laboratory and other aids to diagnosis.

(*e*) Consultations between medical attendant and other practitioners.

(*f*) Maternity benefit, with ante-natal, neo-natal and post-natal care and institutional care and treatment.

(*g*) Dentistry benefit.

The proposal differs from the current United Kingdom system in the following ways:

(*a*) It covers not only employees whose incomes are within a prescribed income limit, but unemployed and unemployable.

(*b*) It covers all kinds of sickness and injury.

(*c*) It provides for all methods of diagnosis and treatment.

(*d*) The medical attendant would have no list of beneficiaries who would look to him for attendance, but would attend patients who came to him of their own choice as in private practice.

(*e*) Patients would be free to change their medical attendant, subject, of course, to the customary professional usages in respect of wrongful supersession and otherwise.

(*f*) The medical attendant would be paid by fee, recoverable from the department, in accordance with a scale of fees and charges agreed upon. The same fee would be payable in respect of all insured patients for the same service; although, no doubt, the unemployed in most cases and the unemployable in all cases, would be non-contributing beneficiaries.

(*g*) Provision would be made to prevent abuse of the system by the medical attendant and overworking the medical attendant by the beneficiaries.

It will be noticed that the proposal is based on the adoption of an income limit and on the payment of fees for individual medical services and not on the introduction of a capitation rate or premium. Later in the year the first report of the Royal Commission was issued and a long chapter was devoted to medical benefits, including medical attendance, the supply of medicines and "other medical benefits." These matters will be found in THE MEDICAL JOURNAL OF AUSTRALIA of May 23, 1925, pages 550 to 553. The recommendations in reference to medical benefit are as follows:

2. That a national health scheme be instituted which will provide adequate medical treatment for the people and which will provide the requisite machinery for the prevention of sickness and accident and

(i) That such scheme be dissociated from the administration of the national insurance fund;

(ii) That the functions and objects of the Health Department be extended in such manner as will enable provision to be made as early as possible for the effective supervision of adequate medical services, especially with respect to maternity treatment.

The proposals of the commissioners were fully discussed in these columns at that time and the significance of the proposals was pointed out. The commissioners suggested that the medical arrangements should include both curative and preventive treatment. In February, 1925, the Hone-Newland report on the cooperation of the medical profession with the Commonwealth Department of Health was considered in minute detail and was adopted. The principles on which this report were based, have been endorsed in other forms since that time by the several Branches and by the Federal Committee. In the report a scheme of preventive medicine is drawn up with the medical practitioner as the unit. Certain duties are imposed on him. The administrative unit is the municipal or shire council and the whole scheme is subjected to a State organization and a Commonwealth organization. One essential preliminary to the scheme is the transfer from the States to the Commonwealth of the laws governing the registration of medical practitioners.

Prior to the issue of the final report of the Royal Commission on National Insurance in 1927, the Federal Committee on learning that the commissioners had determined to advocate the introduction of an insurance scheme without medical benefit and that the services of the medical profession under the scheme would be limited to the matter of certification, submitted certain proposals to Senator Millen, the chairman of the Royal Commission. It was proposed that full-time medical referees should be appointed for the purpose of safeguarding the interests of the public against the giving of loose or false certificates and that severe penalties should be inflicted for the giving of false certificates. The Federal Committee suggested the maximum requirements in regard to the information to be given in the certificates and fixed the fee of five shillings for a certificate if given by a medical practitioner in attendance on the patient or seven shillings and sixpence if given by a practitioner not in attendance. Further, it was suggested that fees of two shillings and sixpence or five shillings should be paid for progressive certificates issued respectively by medical practitioners in and not in attendance on the patient.

The final report on national insurance was submitted to Parliament at the end of April, 1927. The report was published in THE MEDICAL JOURNAL OF AUSTRALIA of May 21, 1927, pages 763 to 769, and of May 28, 1927, pages 800 to 805. It will be remembered that the scheme as recommended to Parliament included the whole of the wage and salary earners of Australia. An income limit was considered by the commissioners and reasons were given for the refusal of the adoption of it. In the discussion on the report in these columns we pointed out that under no circumstances would the medical profession be party to any scheme for the extension of national health insurance to include medical benefit if the beneficiaries embraced all wage and salary earners. According to the report there are twenty-six thousand persons whose earnings exceed five hundred pounds a year. The decision of the medical profession in this regard is definite and irrevocable. The scheme advocated in the report without medical benefit is dependent on a fund to which the Commonwealth, the employer and the insured person would contribute. The insured would be relieved of the obligation to contribute during periods of unemployment or when in receipt of benefits. Provided that no medical benefits are included, this plan is not a matter of concern of the medical profession, although it may affect medical practitioners as citizens. But if medical benefits were attached to the scheme, it would be necessary for the medical profession to make sure that the fund would be sufficient to permit of the payment of fees for services rendered on an agreed scale. The Federal Committee has declared the policy of the medical profession that an extension of the contract scheme is unacceptable and that it does not propose to work in a national health insurance unless fees for work done are paid.

The effect of the report of the Royal Commission on Health of which the late George Adlington Syme was chairman, on the institution of a scheme for the cooperation of the medical profession with the health authorities, has been discussed at considerable length in this journal. The report takes notice of the Hone-Newland report and endorses the principles on which that report was based. In brief it may be stated that the Royal Commission on Health has strengthened the position adopted by the Federal Committee in regard to national health insurance and in particular has made it evident that while the services of the medical profession should be requisitioned in an endeavour to combat disease, no good argument has been put forward in favour of any extension of the contract practice of curative medicine. If any change is to be made in the provision of medical attendance on persons of small incomes, it must be by the removal of the control of the scheme from the friendly societies and the establishment of commissions on which the medical profession would have adequate representation.

## Hospitals.

IN the following an attempt is made to set out categorically the conditions of medical service in the urban public hospitals, the suburban public and private hospitals, the country hospitals and the isolated hospitals in the distant townships. It has been difficult to obtain some of the information and some of the data published have proved to be inaccurate. Notwithstanding the fact that this article is incomplete and may not be entirely reliable, it is thought that its publication may prove of value both at present and in the future in any consideration of the hospital question.

### NEW SOUTH WALES.

The information given is based on the conditions obtaining under the *Public Hospitals Act*, 1898, and the *Private Hospitals Act*, 1908. The new *Public Hospitals Act*, 1929, which has not yet been proclaimed, will no doubt lead to many modifications and alterations.

The Royal Prince Alfred Hospital, the Sydney Hospital, the Royal North Shore Hospital of Sydney, the Royal Alexandra Hospital for Children, the Royal Hospital for Women, the Saint Vincent's Hospital, the Crown Street Women's Hospital, the Lewisham Hospital, the South Sydney Hospital, the Mater Misericordiæ Hospital, the Newcastle Hospital and twenty-four other smaller institutions are not included in the provisions of the older act and under the new conditions will be exempted from those parts of the act that deal with the hospital fund and with the incorporation of hospitals. The larger hospitals are administered under separate acts. The Royal Prince Alfred Hospital and the Sydney Hospital are governed by a board of directors on which the medical profession but not

the honorary medical staff is represented. The former has 520 beds and cots and the number of patients in the institution at one time averages over 490. It has thirty-one public and four private wards. There are sixty-two honorary medical officers, thirty-five salaried medical officers and a nursing staff of 229. The total number of out-patients treated in a year exceeds 52,000. In the year 1926 the government subsidy amounted to £61,500 and £11,050 was granted as special subsidy. Patients contributed £18,667; the charitable public subscribed £31,519, including bequests and donations. The total income from all sources amounted to £138,047. The year's expenditure amounted to £122,757, exclusive of new building, of which £61,906 was absorbed in salaries and wages. The charitable public thus provided 25·7% of the amount spent and the patients 15·2%. The total number of in-patients admitted in the year was over nine thousand, so that the average contribution per patient works out at about two pounds. No patient paid anything for medical or surgical treatment.

The Sydney Hospital has 325 beds and cots and fifty-two in the eye department. The average number of occupied beds works out at about 286. The number of out-patients treated in 1926 was 73,339. The medical staff comprises forty-four honorary and twenty-eight salaried medical officers. The nursing staff comprises 161 persons. There are fifteen wards in the hospital and the same number in the eye department. The government subsidy amounted to £46,881 and the special grant £52,344. The patients contributed £13,771 and the charitable public £27,286. The sum of £92,277 was expended in the year. It thus appears that the charitable public contributed 29·5% of the required money and the patients 14·9%.

At the Royal North Shore Hospital of Sydney there are 158 beds and cots contained in twelve wards. The members of the honorary medical staff number forty-two and there are nine salaried medical officers. The nursing staff has eighty-four members. The government gave the sum of £38,166, including a special grant, the charitable public contributed £14,664 and the patients contributed £7,475. As the total expenditure for the year 1926, exclusive of building, was £46,445, the charitable public provided 31·3% and the patients 16·1%.

The Royal Alexandra Hospital for Children has 344 beds and cots contained in twelve wards. The number of patients in the hospital at one time is often in excess of the number of beds and cots. In 1926 forty medical practitioners were giving honorary service and fourteen were engaged as salaried medical officers. There were 181 nurses. The government subsidy amounted to £25,350. In addition assistance was rendered in the year 1926 for the purpose of new buildings. The charitable public contributed no less than £63,816 and the patients but £7,011. The total amount expended, exclusive of building was £71,158. The charitable public therefore contributed the large proportion of 89·6% of the amount expended in the year and the patients contributed only 9·8%.

It is impossible to give the figures for all the metropolitan public hospitals, as this would occupy more space than is available. Suffice it to state that the twenty-seven hospitals contain 4,041 beds and cots and that in 1926 no less than 353,534 persons were treated in the out-patient departments. The total number of honorary offices held by medical practitioners in the metropolitan hospitals of Sydney is 554. At the present time candidates for appointment to the honorary medical staff of the Royal Prince Alfred Hospital are required, if selected, to resign their appointments at all other hospitals. This condition does not obtain in regard to appointments at other hospitals and in consequence the number of individual medical officers is considerably smaller than the number of offices. There are in the aggregate one hundred and fifty-three salaried medical officers at the metropolitan hospitals in Sydney. The total number of nurses on the hospital staffs is given at 1,750.

The cost of upkeep of the twenty-seven hospitals, exclusive of building, is £681,116. Of this large sum the charitable public contributed as subscriptions, donations, bequests and public collections the sum of £278,321 or 40·8% of the total expenditure, while the patients supplied £113,177 or 16·6%. It is significant that the charitable people of Sydney are prepared to contribute so large a proportion of the cost of upkeep of the public hospitals, in view of the fact that the sixty-six thousand people admitted to the institutions were in a financial position to contribute £113,177 for the cost of maintenance.

The act of 1898 provides for the election of trustees of public hospitals, for the appointment of officers by contributors to the funds of the hospitals, for the holding of property, for the power to recover fees from patients, for the power to invest moneys belonging to the hospitals and for the power to make rules. There are seventy-one hospitals named in the schedule and the act applies to these only. In the list of country hospitals in the Statistical Register of New South Wales one hundred and thirty-two hospitals are mentioned. While the trustees of the hospitals have power to make rules for the government of their institutions, the Minister of Public Health has drawn up model rules for district hospitals which the trustees are recommended to adopt, although there is no legal obligation in this respect. The model rules are dated 1922. The second clause defines the objects of the hospital as follows: To afford maintenance, medical attendance, skilled nursing, necessary appliances and medicines to persons unable to secure them at their own homes. Accommodation has to be provided, if required, for the admission of persons suffering from infectious diseases without danger to other patients. Persons suffering from incurable maladies may be excluded from the hospitals, but must be admitted until they can be safely transferred to a suitable institution on the order of a police magis-

trate or senior officer of police. All persons admitted for treatment must contribute such sum towards the cost as may be decided by the committee after due inquiry, but injured employees of the Government of New South Wales must be treated free of charge. Private patients temporarily unable to secure the usual comforts and attendance of home may be admitted for treatment, provided that special accommodation is provided for such patients and that they pay in advance a weekly sum not less than the actual average cost per occupied bed for their maintenance, nursing, appliances and drugs. A necessitous patient shall, however, have a prior claim to the vacant bed. Private patients may be admitted at their own request and be treated by their own medical practitioner, under certain specified conditions. A place on the medical staff shall be open to every reputable practitioner in the district who desires to occupy one.

Admission to the hospital must depend on the suitability of the patient's condition for hospital treatment. The rules contain exact definitions of the duties, powers and privileges of the committees and subcommittees, of the treasurer, of the secretary and of the medical staff. A rule forbids members of the medical staff to receive money or other consideration for their attendance on any ordinary patient, except such sums as may be annually awarded by the committee. No member of the medical staff may retain his office when elected a member of the hospital committee. The duties and powers of the matron are also defined. The conditions of admission are explicitly set forth and rules for patients and for visitors complete the pamphlet.

Under the new act all public hospitals other than those mentioned in the schedule are to be subject to the control of a hospitals commission comprising a chairman, one legally qualified medical practitioner, one female member, one member representing the hospitals outside the County of Cumberland and one member representing the hospitals within the County of Cumberland. The commission is to be an incorporated body, capable of purchasing, holding, granting and disposing of real and personal property. The commission is to have power to employ officers and others and everyone appointed under the act is to be liable to a fine not exceeding fifty pounds or to imprisonment for a term not exceeding two years, with or without hard labour, if he reveals without lawful excuse any matter affecting any present or past patient of any hospital which has come to his knowledge in his official capacity. All salaries are to be paid out of the hospital fund. The duties of the commission are as follows: To inquire into the administration and management of every hospital, to have every hospital inspected from time to time, to report to the Minister as to the sums required to be provided out of consolidated revenue to meet the needs of the hospitals, to determine what hospitals should be subsidized, to determine what sums of money should be paid from the hospital fund in any financial year to any hospital, to attach to the payment of any subsidy such conditions as it may deem fit, to recommend any amendments of existing legislation and to propose future legislation which it may consider desirable. The Governor may order any incorporated hospital to be closed, any two or more hospitals to be amalgamated and authorize the board of any hospital either separately or together with the board of any other hospital to establish and maintain institutions for the relief of persons suffering from tuberculosis and other infective diseases and of convalescent persons or those suffering from incurable conditions. The hospital fund is to comprise all moneys appropriated by Parliament for the granting of subsidies or other assistance to hospitals and all other moneys paid into the fund under the authority of the act. Public hospitals under the act are to be incorporated. The subscribers to the hospital form the body corporate and the act defines the qualifications of subscribers. Each incorporated hospital is to be governed by a board of directors appointed by the subscribers. The boards may make regulations for the transaction of business, for the appointment of a chairman, a secretary, the medical officers, auditors and other officers, the nursing staff and subcommittees, for the fixing of the amounts to be demanded for maintenance, attendance or relief, for the management of all officers, servants, visitors and patients and for fixing penalties not exceeding two pounds for breaches of the regulations. Every patient admitted to a hospital is to be liable to contribute towards the funds of the hospital according to his means, but not more than the cost of the relief accorded to him. The board may remit or postpone payment of all or of any sums of money due to the hospital for maintenance or the cost of relief. No destitute person is to be refused relief by reason of his inability to pay therefor. The amount paid by a subscriber may be taken into account in determining the amount payable by the subscriber for relief afforded to him or his immediate relatives.

The commission may inquire into the question whether it is desirable to set aside a portion of a hospital for the admission and treatment of persons able to pay for private or intermediate accommodation. No medical practitioner may charge a patient fees for treatment except under conditions specifically prescribed. The act further makes provision for industrial contributory schemes.

From the figures published in the Statistical Register it appears that in 1926 there were 4,204 beds and cots in the hospitals in the country districts of New South Wales. These beds were distributed among 699 public wards and 166 private wards. The total number of honorary medical officers in the country hospitals was 373 and of salaried medical officers 136. The largest extra-metropolitan institution is the Waterfall Hospital for Consumptives, a State institution containing 316 beds and cots with two honorary and three salaried

medical officers. The Broken Hill Hospital has 186 beds, with two honorary and four salaried medical officers. The Newcastle Hospital has 174 beds and cots, with nineteen honorary and seven salaried medical officers. The Camden Carrington Convalescent Hospital has 110 beds. The size of the other hospitals varies between seventy-eight and six beds. The State subsidy for the year 1926 aggregated £237,626, while the special grants and contributions for new buildings amounted to a further £68,345. The subscriptions, bequests, donations and collections yielded £155,828, while the patients contributed £24,746. The total cost of maintenance, exclusive of new buildings, was £567,482.

The *Private Hospitals Act*, 1908, in New South Wales provides for the registration or licensing of all private hospitals. The licence may be held by any person of good character. The management of private hospitals may be entrusted to a registered medical practitioner, a registered midwifery nurse, a registered general nurse or any person approved by the Board of Health. In 1927 there were six hundred and nine private hospitals licensed in the State of New South Wales. Of these 265 were situated in Sydney and 344 in the country districts. The managers of the hospitals are liable to prosecution for structural defects, unhygienic conditions and breaches of the regulations. As a rule warnings are issued before legal proceedings are taken. A relatively strict control is exercised over private hospitals in regard to the occurrence of puerperal sepsis. The total number of beds in the private hospitals in Sydney is 2,904 and in the country districts 2,257. There are 129 private hospitals with over ten beds. The total number of private hospitals licensed for medical or surgical treatment only is forty-seven; there are 358 private lying-in hospitals of which 157 are situated in Sydney or its suburbs and 201 in the country districts. Of the remaining 204 hospitals in which patients are received for medical, surgical or obstetric treatment, 78 are in Sydney and 126 in the country.

### VICTORIA.

The public hospitals of Victoria are under the control of a board appointed in accordance with the provisions of the *Hospitals and Charities Act*, 1922. The board consists of a director or inspector and fourteen other members, four nominated by the Metropolitan Hospitals Association, four nominated by the Country Hospitals Association, two nominated by the committees of subsidized institutions within the metropolis of Melbourne, two nominated by the committees of subsidized institutions outside the metropolis and two other persons, one being a member of the Metropolitan Standing Committee and the other being a member of the Country Standing Committee. The board has the duties of determining the amount of relief needed by the hospitals and charitable institutions, of suggesting the amount of subsidy to be paid to each, of controlling the conditions under which the individual hospitals are governed, recommending the closure of hospitals found to be unnecessary and the amalgamation of two or more hospitals when this expedient is found to be desirable, and of recommending alterations of the law regarding hospitals and charities. The funds of the institutions are collected into the Hospital and Charities Fund to which the State Government contributes a definite sum each year. Every hospital and charity in Victoria has to be registered under the act, but the board has power to refuse to register any existing institution. The Minister is given power to establish and maintain intermediate hospitals and the board is then required to prescribe the regulations under which these hospitals may be managed. All other intermediate hospitals are subjected to the provisions of the law governing private hospitals. Committees of institutions outside the metropolitan area may set aside a part of the institution for the reception of patients able to pay for their maintenance and treatment. The provisions of the act were published in these columns in the early part of 1923.

According to the act no medical or other officer attached to any institution is allowed to accept from patients, either directly or indirectly, any fee for his own use for services rendered at the institution. In the year 1926 54,008 patients were treated in the wards of the hospitals throughout the State, while 193,325 patients were treated as out-patients. The Inspector of Hospitals and Charities recently called attention to the fact that in 1926 14·5% of the population made use of the public hospitals and the average in-patient contributed thirty-five shillings towards the cost of his maintenance. The total number of public hospitals in Victoria when the bill was introduced into Parliament was fifty and there were in addition ninety-eight other charitable institutions. The number of beds in the hospitals was 8,340, of which it was stated that 1,700 were unoccupied. Since that time the act has been in force for six years and a definite line of policy has been established. It would seem, however, that there has been considerable difficulty in translating the policy into action owing to the disinclination of the Victorian Government to provide a sufficient amount of money.

There are in Victoria no less than one hundred and thirty-four subsidized charitable institutions and benevolent societies. The hospitals now number fifty-nine. In the metropolis there are five general hospitals, six special hospitals and two auxiliary hospitals. There are forty-six country hospitals. The total number of in-patients admitted to the general hospitals in the metropolis in 1928 was 24,115. In 1918 the number was 13,243. Subscriptions and public contributions to these hospitals amounted to £60,258, the government grants aggregated £66,439, the municipal grants amounted to £4,748 and the patients' payments yielded £52,556. It is by no means easy to discover from these figures whether the Government, the charitable public, the patients or the municipalities should

bear the deficit of revenue over ordinary expenditure. This amounted to over £29,000. The Charities Board of Victoria frankly disclaims any responsibility in regard to the source of revenue, provided that the Government liberates sufficient amounts to meet the ordinary and extraordinary expenditures. The medical profession is paid in salaries in the five general hospitals of Melbourne £8,742. While the greater part of the work and responsibility entailed in the medical care of the patients is borne by the honorary medical officers, the sum mentioned is small in view of the fact that in addition to over 24,000 in-patients there were more than 84,250 out-patients. Moreover, the salaries were distributed among sixty medical officers; this yields an average per medical officer of £146 a year. At the Melbourne Hospital 8,230 patients were treated in the wards in 1928; at the Alfred Hospital 6,730 in-patients were treated, at Saint Vincent's Hospital 2,737 in-patients were treated, at the Homœopathic Hospital 1,947 in-patients and at Williamstown Hospital 393 in-patients were treated.

In the special hospitals of Melbourne no less than 16,446 in-patients and 55,822 out-patients were treated in 1928. The in-patients treated in 1918 numbered 9,260. The increase in ten years is therefore about 77%. For several years the Charities Board of Victoria has realized that the position in Melbourne is extremely unsatisfactory. In spite of constant appeals to the Government nothing has been done to meet an urgent problem. The board has advocated the expenditure of about two million pounds in five years to bring the hospitals in the metropolis into a position to meet the requirements of the indigent sick. The scheme has been put forward to erect a new hospital at Parkville and to bring this new hospital into close proximity with the medical school. The Government found that the proposed site was needed for the building of a high school. The board suggested that another site be procured for the high school. Unfortunately other obstacles were placed in the way and up to the present nothing has been done to remedy the defect. Some relief as far as shortage of beds is concerned has been gained by the utilization of the hospital at Caulfield for patients with acute illness and by the provision of additional accommodation at the Alfred and Saint Vincent's Hospitals. In 1927 the board sought expert assistance in connexion with hospital administration and the problems of the medical arrangements in hospitals. At its request the Victorian Branch of the British Medical Association appointed a committee of seven to act as a medical advisory committee. The members were Dr. A. V. M. Anderson, Dr. T. E. V. Hurley, Dr. L. S. Latham, Dr. R. G. McPhee, Dr. J. Newman Morris, Sir George Syme and Dr. B. T. Zwar. This committee has assisted the board during the eighteen months since its appointment.

It is part of the policy of the Charities Board of Victoria to establish community hospitals and it appears that within a short time four hospitals planned on lines laid down by the board will be instituted at Sale, Stawell, Wangaratta and Castlemaine. At first it was thought that fresh legislation would be needed, but the board has been advised that hospitals for the reception of non-paying patients, patients able to pay partial fees, the so-called intermediate class, and private patients can be established under new regulations to the existing act. The board is not prepared to establish community hospitals in Melbourne until it has demonstrated the soundness of the scheme in the smaller centres. In the meantime the position in Melbourne remains unsatisfactory from several points of view, notwithstanding the fact that the three leading hospitals and the special hospitals are admirably managed and well staffed.

The country hospitals have been improved to a much greater extent than have the metropolitan hospitals. In the first place the base hospitals and some of the district hospitals have been improved to conform to a standard that has been set up by the board. A considerable amount of control has been exercised over the forty-six hospitals in the country. As pointed out above, the board has power to close hospitals, to amalgamate two or more institutions and to establish new hospitals where they may be needed. Two new hospitals under the scheme adopted by the board will shortly be opened at Ouyen and at Orbost. Sanction has also been given for the establishment of new hospitals at Dandenong, at Lilydale and at Korumburra. That there is still much to be done in this direction is evident from the fact that on June 30, 1928, there were in the whole of the State 1,516 unoccupied beds. The total number of patients admitted as in-patients to the country hospitals in 1928 was 23,966. Ten years before there were 16,095. The number of out-patients in 1928 was 9,720.

In regard to the revenue and expenditure it appears that the patients paid £50,490 for maintenance, that the Government contributed £42,155 as grants and the municipalities £9,985, making £52,140 as the combined grants, that the public contributed in the form of subscriptions and public collections £64,982. The total ordinary revenue aggregated £130,344, while the total ordinary expenditure aggregated £119,112.

Many of the country hospitals have obstetrical departments. In the year 1928 530 infants were born in twenty-two of the subsidized hospitals in the country. The largest department is at Ballarat. The hospital at Hamilton also has a large lying-in department.

Of the forty-six country hospitals thirteen have no salaried medical officer, twenty-three have one each, three have two each and six have three each. The aggregate salaries of these forty-seven medical officers was £6,521, which yields an average of £120 a year.

The board is advocating the appointment of almoners and of dietitians. The latter would be valuable in connexion with administration and in

assisting the physicians in their application of therapeutic measures in diet. There is further the matter of teaching nurses dietetics.

The Charities Board of Victoria has planned the establishment of medical centres for the purpose of providing skilled aid in diagnostic work in the outer suburban districts. It is proposed to equip the centre with scientific apparatus and to place it under experienced medical specialists. The centre would comprise a free dispensary where indigent persons could receive attention and treatment for minor ailments. No fees would be charged, but the patients would have to prove their inability to pay private fees. It would further contain a consulting department with X ray, pathological, biochemical and other scientific divisions under competent practitioners. No patient would be received without a letter of recommendation from his or her medical attendant. Fees would be charged according to the means of the patient. There would also be a public health and tuberculosis dispensary, a baby health centre and a visiting nurses' centre. It is suggested that a trial medical diagnosis bureau be established at Footscray. The reception of this scheme by the medical profession will depend entirely on the manner in which the centres are conducted. In principle the idea deserves support.

There are at present 216 private hospitals registered under the act in the metropolitan area and 257 in the remainder of the State of Victoria, making 473 private hospitals in all. These hospitals contain 4,012 beds, of which 1,155 are reserved for patients needing medical care, 1,185 for patients needing surgical treatment, fifty-four for patients suffering from notifiable infective diseases and 1,618 for women in child-birth. The Public Health Department exercises control over these hospitals.

There is one hospital in the State to which persons suffering from notifiable infective diseases only are admitted. This is the Queen's Memorial Infectious Diseases Hospital at Fairfield. It has accommodation for six hundred patients. The control of this hospital is also in the hands of the Public Health Department. Any council or combination of councils may build a hospital or make other arrangements for the accommodation of persons suffering from any infective disease. When a council undertakes the establishment of such a hospital, either on its own initiative or in obedience to the requirements of the Health Commission, the Government renders itself responsible for half the expenses and costs incurred. In addition to the one fever hospital mentioned above, seventeen general hospitals and one private hospital have isolation blocks or wards for persons suffering from notifiable infective diseases.

### QUEENSLAND.

The control of public hospitals in Queensland is entrusted to the Home Secretary's Department. In Brisbane the great metropolitan hospitals are governed by the Brisbane and South Coast Hospitals Board. TheMedical Superintendent of the board is at the same time Medical Superintendent of the Brisbane General Hospital. The Medical Superintendent of the Hospital for Sick Children acts as Deputy Medical Superintendent of the board. The resident medical officers are appointed by the board and are transferred to each of the four hospitals under its control, namely, the Brisbane Hospital, the Hospital for Sick Children, the Lady Bowen Maternity Hospital and the Lady Lamington Hospital. The Medical Superintendent at the Brisbane Hospital is not only the chief administrative officer, but he also has a large measure of control over the surgical arrangements and the treatment of patients in the hospital. There is little difference between the methods of control, the manner of appointment of the members of the medical staff and the conditions of admission of patients at this hospital and at public hospitals in other cities in Australia. The Mater Misericordiæ Public Hospital is staffed by resident medical officers who are promoted in stages of four months' service for twelve months. The members of the honorary medical staff in the Brisbane hospitals are appointed under the usual conditions and have full control of their patients. In the provincial cities the arrangements in the hospitals vary with the size of the institutions. At Toowoomba and at Ipswich there are two resident salaried medical officers and a staff of elected honorary medical officers. At Rockhampton the Medical Superintendent resides in the hospital, but there are no other salaried medical officers. The management of these hospitals is carried out under the control of boards of management representing the local subscribers to the funds. The regulations are more or less defined in the *Hospitals Act*, but considerable latitude is allowed in the adaptation of the regulations as adopted by the boards.

The *Health Acts*, 1900 to 1922, contain provisions for the control of private hospitals and of lying-in hospitals. The regulations promulgated under these acts bear the date of 1916. According to these regulations every private or lying-in hospital must be registered by the local authority, not by a central board nor by the Commissioner of Public Health. The licensee must inform the local authority when a resident medical practitioner or a registered nurse is placed in charge of a private or lying-in hospital. Special instructions are issued in regard to the correct procedure in the event of a patient suffering from puerperal fever or from other notifiable infective disease, being in a private hospital or lying-in hospital. It is necessary for the Governor-in-Council to declare an area or division of an area as being an area or division in which the provisions of the part of the *Health Acts* dealing with lying-in hospitals shall apply. There are 204 registered private hospitals in Queensland, of which 125 are registered as lying-in hospitals. The hospitals are registered under the name of a registered nurse in the majority of instances, although 27 names of medical prac-

titioners are entered on the lists. The exercise of control over the satisfactory management of these institutions varies considerably in the different parts of the State.

### South Australia.

The hospitals in South Australia are either government hospitals or hospitals subsidized by the Government. The hospitals are under the control of the Inspector-General of Hospitals. In addition there is one children's hospital and many private hospitals. The municipal bodies can be required to pay a specific annual contribution towards the upkeep of public hospitals in accordance with the provisions of the *Rating for Hospital Purposes Act*, 1919.

There are nine general public hospitals under the Government. The Adelaide Hospital is governed by a board of three members, including the Inspector-General of Hospitals and two other government nominees. The honorary medical staff comprises fifty medical practitioners. There are two salaried surgeons in the night clinic department and fourteen dentists. The salaried staff contains a medical superintendent, a medical registrar, a surgical registrar and eighteen resident medical officers. The hospital contains five hundred and thirteen beds. Patients are admitted on the recommendation of subscribers, medical practitioners, members of the board or approved organizations. Patients pay up to ten shillings a day, according to their means. Patients able to pay for private treatment are not admitted. The total number of patients treated in the wards in 1928 was 9,117. In addition 8,880 out-patients were treated. The patients contributed £11,327, the public subscribed £1,018 and the municipalities paid £20,660, making a total of £33,005. The expenditure during the year aggregated £103,497.

The members of the honorary medical staff are appointed for a term of three years, but are eligible for reelection until they have served for a period of twenty years. The medical superintendent is resident in the institution and is a salaried officer. He is appointed for three years, but can apply for reappointment. The registrars and the resident medical officers are appointed for a period of one year.

There are no private wards in any of the government hospitals. No fees for medical attendance are charged.

Of the seven government hospitals in the country, two have seventy-two beds each, one has fifty beds, one forty-eight, one forty, one thirty-two and one six. The majority of these hospitals has one medical officer.

There are thirty-seven subsidized hospitals. Nineteen of these hospitals have between eleven and nineteen beds, nine have between twenty and twenty-nine beds, six have between thirty and thirty-nine beds and three have between forty and fifty beds. The average number of beds occupied during the year varies very widely. The patients contribute close on £50,000, while the total expenditure in the upkeep of these hospitals is about £100,000. The medical officers at the government hospitals are paid a nominal salary and have the right of private practice. The same obtains at the subsidized hospitals. There are private wards or beds at several of the subsidized hospitals for which additional fees are charged.

The Mental Hospital at Parkside is a government institution controlled by a board of three members. The medical staff comprises the superintendent, the deputy superintendent, one junior medical officer, one resident medical officer and four honorary medical specialists. The nursing staff comprises a matron, an assistant matron, eighty-two nurses and one hundred and one attendants. The average number of patients in the hospital is 1,326. Destitute patients are treated free of charge, while others are charged up to two guineas a week.

The Enfield Receiving House has a visiting medical superintendent and a visiting deputy medical superintendent. The average number of patients in the institution is thirty-seven. Patients pay up to four guineas a week, according to their means.

A new mental hospital at Northfield will be opened next month. There is accommodation in the part now completed for one hundred male patients.

There are two sanatoria for patients suffering from pulmonary tuberculosis. The Bedford Park Sanatorium is a government hospital for persons suffering from the disease in its early stages. It contains fifty-nine beds. There is one medical officer.

There is also a branch of the Adelaide Hospital, situated in North Terrace, Adelaide. The average number of patients in this institution is sixty. Patients with advanced disease are admitted.

A third instituton for patients suffering from tuberculosis and malignant disease is in course of erection at Northfield.

Patients suffering from the notifiable infective diseases are admitted to the special isolation block in the Adelaide Hospital. There is accommodation for one hundred and forty-four patients. A new institution is almost completed at Northfield.

There are no maternity or lying-in hospitals under the direct control of the Government. Several of the subsidized hospitals in the country have beds for lying-in patients and labour wards.

### Western Australia.

The hospitals in Western Australia are divided into three classes, the large metropolitan public hospitals of which there are three, the departmental or government hospitals, numbering twenty-seven, and two special hospitals and the assisted hospitals, numbering forty-nine. It has been pointed out that the hospital system in the State developed as an undertaking of the Government. In the early days the local communities were not prepared to establish hospitals and in consequence the Government assumed the whole responsibility. The Perth

Public Hospital and the Fremantle Hospital are general hospitals governed by the board under the control of the Government. The appointments to the honorary staff and of the salaried medical officers are made by the boards with the approval of the Department of Health. Similarly, the Children's Hospital is managed by a board for the Government. Admission to these hospitals is limited to those of small means who cannot afford to pay for treatment elsewhere. At these three hospitals the honorary medical officers give unremunerated service and do not accept fees from patients under any circumstances. The Perth Hospital has accommodation for 240 patients. Actually the average number of patients admitted to the main institution in Murray Street is 306. In addition 40 patients are usually under treatment at the Infectious Diseases Hospital at Subiaco. This hospital is a branch of the Perth Hospital, as is the convalescent home known as Kalamunda, where 26 patients are in residence. The main Perth Hospital contains 58 beds for patients admitted for the Repatriation Department and an observation ward for persons suffering from mental disease. The Perth Hospital occupies an area of about four acres and there is no room for further expansion. The hospital is organized as a general public hospital and has the usual departments for special diseases or for the diseases of special systems. The government subsidy in 1927 amounted to £35,477, subscriptions, donations and the like yielded £7,439, while the patients' contributions resulted in £22,380. It thus transpires that the public provided 10·17% of the revenue required and the patients contributed 30·6%. The relatively poor response by the charitable public is no doubt due to the fact that the Government has accepted the financial responsibility for the institution. This argument, however, does not hold good for the Children's Hospital. The public contributed £9,714 or 46% of the amount expended, excluding the cost of building, the patients contributed £2,529 or 11·97% and the subsidy amounted to £7,500 or 35·5%. It is interesting to note that the entertainment tax enabled the Government to allocate no less than £41,347 of the moneys collected to the hospitals. Of this sum over £15,000 was paid to the three public hospitals. The Children's Hospital contains accommodation for 116 patients apart from fourteen in the isolation block. At the Fremantle Hospital there are beds for ninety-one patients, but additions are being made to the hospital which will result in an additional thirty-seven beds. The number of in-patients treated in 1927 in the Perth Hospital was 6,191 and of out-patients 45,616; in the Children's Hospital the in-patients numbered 2,112 and the out-patients 40,128; at the Fremantle Hospital the in-patients numbered 1,359 and out-patients 26,267.

Of the twenty-seven departmental hospitals, two are leased to nurses under definite conditions. The average number of occupied beds varied in 1927 from 55·4 at Kalgoorlie to 0·1 at Menzies. Ten of the hospitals are of moderate size; many of them are neither modern nor suited to their requirements, although very excellent work is carried out in them. The total number of patients admitted to the departmental hospitals in 1927 was 7,263. The hospitals at Northam, Geraldton, Kalgoorlie and Collie absorbed 3,192 of this number. In addition to the hospitals mentioned above there are two government hospitals of importance. The first is the Wooroloo Sanatorium, a fine institution capable of accommodating about 150 patients, and the second is the King Edward Memorial Hospital for Women at Subiaco, a maternity hospital with beds for 42 patients. In the year 1927 no less than 1,002 patients were under treatment and 900 babies were born.

There are forty-nine so-called committee or assisted hospitals in Western Australia. In 1927 the average number of occupied beds at these institutions was 130. The majority of these hospitals has been built by the local communities with aid from the Government. The Department of Health exercises a kindly control over them and encourages the committees to make provision for the patients requiring institutional treatment in the districts. The patient who can afford to pay fees to the medical attendant, is permitted to do so. As a rule the management is satisfactory and the committee and the local medical practitioners work amicably for the benefit of the patients and the institutions.

### TASMANIA.

The hospitals in Tasmania are with relatively few exceptions government institutions and their revenue is derived largely from consolidated revenue. The public hospitals are open to any person in need of treatment for illness or injury, no matter what his financial position may be. No person may obtain private accommodation in a public hospital in consideration of payment of money or of other reward and no discrimination may be made in a public hospital in respect to the social position of patients. Admission to a public hospital is determined solely on the ground of suitability from the point of view of the illness or injury requiring treatment.

The large public hospitals are situated in Hobart, Launceston, Latrobe and Scottsdale. The average number of patients in the Hobart Public Hospital is 199. The average number of patients in the Launceston Public Hospital is 167. The Devon Hospital, Latrobe, houses on the average 71 patients, while there are usually 44 patients in the Tasmanian Sanatorium for Consumptives, close to Hobart. The North-Eastern Soldiers' Memorial Hospital at Scottsdale contains around 22 patients. The hospitals at Zeehan, at Queenstown and at Campbell Town have accommodation for less than 20 patients, while there are five smaller public hospitals.

The management of the public hospitals is vested in a board comprising eight members. The Governor appoints five members, the registered medical prac-

titioners residing and practising in the district nominate one, the local authority or authorities elect two members. In the case of the Hobart and Launceston Hospitals the boards consist of eleven members, seven appointed by the Governor, one nominated by the registered medical practitioners residing and practising in the district, two elected by the municipal council and one nominated by the Friendly Societies' Association. The board appoints the medical officers under direction of the Chief Secretary. The surgeon superintendents of the Hobart, Launceston and Devon Hospitals are paid a salary varying between £650 and £1,000 *per annum*. At present there are no honorary medical officers attached to the Hobart Hospital. One visiting surgeon is paid £300 a year. The resident medical officers at Launceston and Latrobe are paid from £200 to £400. There are at these two hospitals staffs of honorary medical officers. The medical officers for the smaller hospital districts are paid salaries said to be determined by the services rendered. The majority of the more important appointments are for a period of three years; in some instances the appointment is for one year only.

In the three large hospitals the medical arrangements are under the control of the surgeon-superintendent, the nursing arrangements are controlled by the matron and the administrative arrangements are under the direct control of the boards of management. The medical officers of the hospitals are subject to the control of the surgeon-superintendent. In the public hospitals the patients are required to pay for their maintenance according to their means, but, as stated above, they are not permitted to pay fees to the medical officers for treatment. The ability of the patient to pay for his maintenance is determined by inquiry instituted by the management of the hospital. It is specifically provided that no patient shall be refused admission to a hospital or treatment within the institution on account of his inability to pay for his maintenance.

The largest maternity hospital is the Queen Alexandra Hospital, Hobart. It is controlled by a board of management and receives a substantial government subsidy. All classes of patients are admitted. The fees charged for the attendance on patients in the hospital vary according to the services required and medical practitioners giving the obstetrical and gynæcological services are allowed to charge fees. The members of the medical staff carry out ante-natal supervision and attend on patients at and after their confinements free of charge when the patients are unable to pay fees. The number of patients confined at this hospital in 1928 was 398. The same conditions obtain at the Queen Victoria Hospital at Launceston. The number of women attended at their confinements in 1928 was 260. A new maternity block has recently been added to the Devon Hospital at Latrobe. In addition to these three public lying-in hospitals there are scattered throughout the State many small private lying-in hospitals, licensed by the Department of Public Health and managed by registered midwifery nurses. Private hospitals have to be licensed and are liable to inspection by the Chief Health Officer. The persons in charge of private hospitals must be either medical practitioners, hospital nurses, certified midwives or other persons approved by the Chief Health Officer.

There is no special hospital for children in the State. The Hobart Hospital and the Launceston Hospital possess blocks containing about forty beds for the medical and surgical care of children. In the majority of the smaller hospitals children are admitted to the wards set aside for female patients.

Persons suffering from notifiable infective diseases are admitted to the Vaucluse Hospital, Hobart, in the south of the island or to the isolation hospital in Launceston in the north. The Vaucluse Hospital contains about sixty beds. It is administered by the municipal council of Hobart. The cost of relief of patients from other municipalities in the south is borne by the municipal district from which they come. In the Launceston Isolation Hospital there is accommodation for fifty patients. There is also an isolation wing in the Devon Hospital at Latrobe. The same conditions obtain in regard to the admission of patients from surrounding districts as in Hobart. A hospital board can be compelled to establish isolation accommodation for patients suffering from notifiable infective diseases.

There is a sanatorium for sufferers from tuberculosis at New Town, outside Hobart. It contains sixty-five beds. It is the only establishment of its kind in the State. It is controlled by a board of management and the medical officers give their services in an honorary capacity.

It will be gathered that in Tasmania the original objective of the public hospital has been destroyed, namely, the provision of asylums, the medical attendance and nursing care and maintenance of poor persons during periods of illness or incapacity from injury. While hospitals are opened in other parts of the British Empire for persons other than indigent patients and inability to pay for the necessary treatment elsewhere is usually regarded as the qualification for admission, the hospitals in Tasmania have open doors for all sick persons. The patients are treated alike and are required to pay for their maintenance or for as much of it as they can afford. The local authority is not encouraged to support the local hospital, but the Government pays a substantial proportion of the expenditure, at times reaching 69%. It is claimed that under this system patients able to afford treatment in private hospitals, do not seek admission to the public hospitals, but it is obvious that the system of providing everyone with skilled medical attendance for which no one pays one penny, is likely to lower the self-respect of the people. We refer to the conditions in the north where the honorary medical officers give gratuitous attendance. We refrain from commenting on the conditions that have obtained in the south for ten years.

The Medical Journal of Australia

SATURDAY, AUGUST 31, 1929.

## The General Practitioner.

THE object of the Education Number of THE MEDICAL JOURNAL OF AUSTRALIA is to present to those who are contemplating or who have already embarked on a career in medicine, information concerning the special training of the undergraduate in medicine, concerning medical practice in its various phases, concerning the public medical services and concerning the manner in which medical knowledge is gained and made available for the public benefit. To restrict such an issue to the narrow limits of the medical curriculum and the facilities offered by the several training schools is to ignore the most important message that should be delivered to the medical practitioner of the future. The practice of medicine is not a trade and those who follow it, should never lose sight of the obligations they have accepted when they enter the medical profession and the privileges they enjoy in their professional capacity.

It will be gathered from these few words that this education number is unorthodox, judged in the light of the usual conception of the term. In order that the picture of medical practice may be clear, reliable and of value, we have followed the exceptional course of inviting five distinguished practitioners, selected because of their special experience, their sound outlook on medical problems and their ability to act as mentors, to write special articles on medical practice in the city, medical practice in the suburbs, medical practice in the country, practice in the specialties and lodge practice. The five articles will be found to be stimulating, useful and frank. Dr. Gledden has a warning to hand to the young graduate who may be undecided whether the city has or has not some tempting baits for him. He has eschewed minute details of the life of the general practitioner in a large city; he might have drawn some almost dramatic pictures of the fleeting figures in the *clientèle* of the city practitioner, of the expedients adopted at times to secure frequent beckons to fashionable hotels, of the fascinating but not satisfying episodes of crowded centres and cosmopolitan resources. Instead he has boldly attacked his subject and has based his sound advice on a ripe experience. Dr. Pern has placed his readers under a debt of gratitude to him by depicting the life of the general practitioner as it should be, but, alas, rarely is! His supreme skill in compelling those who ponder over his utterances, to recognize the duties of a conscientious medical practitioner to the community, can be commended as the soundest lesson imaginable for the young graduate. Dr. Halloran, too, strains every nerve to raise the dignity, status and value of the specialist's work. Dr. Lawes is eminently practical and his contribution to the subject is constructive and of immense value. Dr. Rosenberg has sought and found the weak point in the modern method of providing treatment for the mass. His appeal for leisure to raise the level of service and to combat disease in the abstract as well as to attack it in the concrete indicates a reform that should be introduced for the benefit of the human race. We tender our sincere thanks to the five authors who have consented to put into words thoughts that often are repressed or pushed aside.

To the young undergraduate and young graduate in medicine we would address a few words of advice. When you pass through the portals of the medical profession and gain the right to be registered as medical practitioners, you accept obligations that you cannot evade. You choose medicine as a calling in order that the knowledge you acquire in your university and in your practice may be used for the benefit of those who seek your aid. You are given opportunities of wrestling with disease and its menace to human life. You will be appealed to to do what is humanly possible to save life, to alleviate suffering, to mitigate the agony of death. You will be trusted with the most intimate secrets of human life; you will be welcomed as the guide, comforter and friend. Beware how you accept these

acts of trust. If you should prove yourself unworthy, you will have forfeited your very soul. No monetary reward can compensate you for the loss of self-esteem that must follow if you permit anything to interpose itself between yourself and your duty to your patient. The medical profession has earned a high place in the opinions of mankind. It has acquired a dignity and a tradition. Aim at the highest ideal and you will help to maintain that dignity and tradition.

You will have opportunity of contributing to the common knowledge concerning the human body and the diseases that attack it. Remember that you owe it to the world to share that knowledge. If you are fortunate enough to gather knowledge from experience, you have no right to keep the facts to yourself. It is your first duty to impart your valuable knowledge by writing or speaking to your colleagues and thus indirectly to humanity. If you have aptitude and opportunity for original research, you are bound to make sacrifice in order that your gifts may be dedicated to the human race. You have gained the training, the fundamental knowledge, the skill to learn through the sacrifice of others. You must be prepared to carry out your own part in the ceaseless endeavour to raise the health and happiness of the universe.

You have obligations to your colleagues and to your profession. Remember that the medical ethical code has been devised to enhance the value of your profession in its ideals and to promote a comradeship and feeling of amity among its members, that their combined efforts may be fruitful. Look leniently on the shortcomings of others and help them to attain the esteem and respect of their contemporaries. Your own profession will judge you justly and truly, without fear or favour. See to it that it will not find you wanting.

## THE BRITISH MEDICAL ASSOCIATION.

ON another page of this issue reference is made to the constitution of the British Medical Association and to some of the privileges of membership of this large organization. Mere largeness is not necessarily an index of importance, but numerical strength is essential to the soundness of a representative institution. Attention is called to the fact that it took the British Medical Association forty years to attain the same membership as that now enjoyed by the Branches in Australia. Three of the Branches, namely, the New South Wales, the South Australian and the Victorian, received official recognition in the year 1880, that is forty-nine years ago. The Queensland Branch was recognized by the Council of the British Medical Association in 1894, the Western Australian Branch was recognized in 1899 and the Tasmanian Branch in 1911. The growth of the Branches in Australia has therefore been extraordinary. With few exceptions every medical practitioner engaged in some form of practice seeks to become a member of the Association and as a result the proportion of the members of the medical profession who are members of the British Medical Association, is very high. This fact means that the organization is a valuable instrument to the medical profession and its membership is regarded as essential.

Apart from their absolute and relative size the Branches of the British Medical Association in Australia are regarded by the community as important bodies. It is recognized that the Councils of the Branches expend an immense amount of knowledge, skill and energy in the planning of scientific meetings that are held month after month in the capital cities of the six States. In this way the members receive an impetus to attain a high standard of competence and are given an opportunity to contribute to the advancement of medical knowledge. While the charlatan blazes his impudent claims far and wide and uses all sorts of devious devices to cheat the people into the belief that he can cure by unorthodox means, the public realizes that the members of the British Medical Association are not permitted to advertise themselves or their methods of treatment and that each member practises his profession in accordance with those standards that have been set up for the guidance of an honourable profession. Governments consult the British Medical Association and its Branches before they introduce reforms and its opinion on matters concerning the health of the

community is always sought by responsible bodies. The Branches in Australia have manifested a great deal of activity in the endeavour to regulate friendly society lodge practice, because it is recognized that unsatisfactory conditions of service are detrimental to good work and consequently not in the best interests of the lodge patients themselves. Moreover, the medical profession has been exploited in the past by the friendly societies. It was not until the Councils of the Branches of the British Medical Association undertook the negotiations with the friendly societies and determined the conditions under which lodge medical officers would give attendance to the lodge members that the practice of individual bargaining with medical practitioners was stopped.

In addition to the scientific work, the promotion of preventive medicine, the regulation of the ethical behaviour of members, the improvement of the conditions of employment in the public medical services and the proper control of contract practice, the British Medical Association has further advantages to offer to its members. It brings medical practitioners more closely together, provides them with opportunities to know each other intimately and thus it establishes good fellowship and friendly relations. It relieves the individual member of the necessity of defending his profession when scoffers make unjustifiable attacks on its traditional methods and on the conduct of its affairs. It unites the medical profession into one strong body that can afford to treat with contempt ignorant persons who pit their opinions against those of its most eminent members. It provides its members with the high ideals that actuated Charles Hastings to found the Association close on a century ago and enhances the chance of attaining his objectives because the efforts of the British Medical Association are concerted efforts of many individuals.

The young graduate will recognize in these arguments strong reasons for inducing him to apply for membership as soon as he is enrolled as a registered medical practitioner. He will meet with a warm welcome and much kindly and valuable help. He will find among the members many of his old 'varsity friends, many of his former teachers, many men and women with whom he will work in friendly competition. He will learn a great deal concerning the world and its ways during his intercourse with his colleagues as members of a great organization. He will discover that some of his senior colleagues are giving time, effort and wisdom in the attempt to render the whole medical profession of still greater benefit to the community. In short, he will cherish his membership of the British Medical Association as one of his most precious possessions.

## Medical Education in Australia.

THE information published in this Education Number in regard to the curriculum at the three medical schools of Australia consists of a condensed outline. A full account was published in the Education Number of June, 1925. It is hoped that next year a full account will again be given. It may be concluded that the influence of the war on the number of medical students in the several schools has vanished and the numbers are in accord with the natural inclinations and aspirations of the younger members of the community. Some figures are published in regard to the Universities of Melbourne and Adelaide. It has unfortunately been impossible to obtain complete figures for the University of Sydney.

### THE MEDICAL SCHOOL AT THE UNIVERSITY OF SYDNEY.

Intending students at the University of Sydney are required to have passed the school leaving certificate examination or matriculation and to produce evidence that they have passed an examination in elementary chemistry and physics. These subjects may, however, be taken at the end of Trinity term of the first year. In the first year the student devotes time to the study of zoology, chemistry, physics and botany. At the end of the year he sits for the first degree examination. The subjects studied during the second year are anatomy, histology and physiology and work is also carried out in the dissecting room. At the end of the second year he is required to pass the second degree examination. During the third year further work in dissection is carried out and the subjects for study include biochemistry, experimental physiology, the physiology of the special senses and pharmacology. At the end of the third year the student is required to sit for the third degree examination. Having satisfied the examiners he proceeds to the study of pathology and the fourth degree examination is confined to this subject. In the fourth year the student attends lectures on *materia medica*, therapeutics and obstetrics and gynæcology. Late in the

fourth year he begins the study of surgery. As a result of a recent rearrangement the systematic lectures and demonstrations in diseases of the skin, diseases of the eye and disease of the ear, nose and throat are given together with those on gynæcology in the long vacation between the fourth and fifth years, so that the students are enabled to bring some theoretical knowledge to their practical work on these subjects in hospitals. Hospital work is carried out at one of the three teaching hospitals, the Royal Prince Alfred, the Sydney or Saint Vincent's Hospital. In the fifth year the student continues the study of medicine and surgery and is required to pass the fifth degree examination. The last year is devoted to hospital practice in medicine and surgery, to the study of clinical pathology and of medical jurisprudence and medical ethics. He then presents himself for his final examination, provided he has attained the age of twenty-one years. The final examinations are held in August and a deferred examination is held in March for those who fail by a small margin.

The final examinations are for degrees of bachelor of medicine and bachelor of surgery. The fees for the whole course amount to £235 and this amount includes the sum payable for hospital attendance and examination fees.

Owing to the creation of the Bosch chairs in medicine and in surgery and in bacteriology it is not unlikely that a certain amount of rearrangement of the work in the latter years of the course will be found necessary.

A graduate of two years' standing may proceed to the degree of doctor of medicine or to that of master of surgery. For the former degree he is required to present a thesis embodying the results of original investigation and he must be prepared to submit to an oral examination and to be examined on the subject of medicine generally and on that of his thesis. For the degree of master of surgery he is examined in general surgery, surgical anatomy and pathology, operative surgery, clinical surgery and the special branches of surgery; a thesis must also be submitted. The fee for the higher degree is £20.

The University of Sydney grants diplomas in public health, in tropical medicine and in psychiatry. In each instance the candidate is required to have passed through a prescribed course of study and to have carried out special work at selected institutions. The course in tropical medicine is held at the Australian Institute of Tropical Medicine. The fees in each instance are ten guineas. Reference has been made in another place in this issue to the new School of Tropical Medicine and Hygiene which is being founded at the University of Sydney.

The number of students who passed the final degree examination in August, 1927, was 52 and 25 succeeded in satisfying the examiners at the deferred examination in March, 1928.

## THE MEDICAL SCHOOL OF THE UNIVERSITY OF MELBOURNE.

Students at the Medical School of the University of Melbourne are required to have passed a preliminary examination. This examination is the school leaving examination and the subjects required are English, mathematics, another language and two subjects provided that Latin and geometry are included. On entering the medical school the student spends one year in the study of chemistry, physics and zoology and botany and sits for an examination in these subjects at the end of the year. During the second year he studies anatomy, embryology, histology, neurology, physiology and topographical anatomy. These studies are continued through the third year and in addition work is undertaken in applied biochemistry, experimental physiology, the physiology of the special senses and pharmacology. The student must dissect two whole bodies. At the end of the third year he is required to pass the second professional examination in anatomy and physiology. He then proceeds to the fourth year and receives lectures on pathology, bacteriology, *materia medica*, therapeutics and obstetrics and gynæcology. He also does practical work in each subject. Some time is devoted to advanced anatomy. Late in the fourth year he starts the study of medicine and surgery. In the fifth year he studies clinical medicine and surgery, obstetrics, gynæcology, pædiatrics, ophthalmology, oto-rhino-laryngology and dermatology. For his clinical work in the wards and in the out-patient department he is attached to the Melbourne Hospital or to the Alfred Hospital or to Saint Vincent's Hospital. He is required to attend twenty women in labour and for this purpose goes into residence at the Women's Hospital. Some time is spent in the investigation of the commoner infections at the Infectious Diseases Hospital at Fairfield and attention is given to the subject of psychiatry at one of the hospitals for the insane or at a reception house. In his sixth year the student attends lectures on medical jurisprudence, medical ethics, psychiatry and operative surgery. At the end of the second term in the sixth year he sits for the final examination in medicine and surgery, obstetrics and gynæcology.

The fees for the course, including those for the examination of bachelor of medicine and bachelor of surgery, are £270.

The following figures give some indication of the numbers of students in the Medical School at the University of Melbourne.

In 1919 there were 209 first year students, in 1920 202, in 1921 151, in 1922 111, in 1923 91, in 1924 65, in 1925 75, in 1926 61, in 1927 71, in 1928 73, in 1929 85.

The number of persons who have graduated in the respective years has been as follows: In 1909 45, in 1910 48, in 1911 58, in 1912 22, in 1913 52, in 1914 63, in 1915 84, in 1916 72, in 1917 54, in 1918 68, in

1919 14, in 1920 62, in 1921 59, in 1922 91, in 1923 107, in 1924 131, in 1925 145, in 1926 124, in 1927 45, in 1928 83.

### THE MEDICAL SCHOOL AT THE UNIVERSITY OF ADELAIDE.

Admission to the Medical School of the University of Adelaide is conditioned by the passing of at least four subjects, including English and one other language, at the Leaving Examination and such of the following subjects as have not been passed at the Leaving Examination must have been passed at the Intermediate Examination: Latin, one language other than English and Latin, physics, chemistry and, unless mathematics Part I has been passed at the leaving standard, mathematics Part I and Part II. The subjects of the first year are physics, chemistry, botany and zoology. The first examination at the end of the first year includes all these subjects. In the second year the student enters the dissecting room and studies anatomy, histology, neurology and embryology. He also engages in the study of physiology and biochemistry. He attends lectures while he is carrying out the practical work. Anatomical dissections and lectures in anatomy and physiology are continued in the third year and instruction in pharmacy and pharmacology is also undertaken. At the end of the third year the second examination is held. The student must satisfy the examiners that he has acquired a reasonable amount of knowledge in anatomy, histology, biochemistry, physiology and pharmacology. After the second examination has been passed, the student begins his clinical work. He attends lectures on the principles and practice of medicine and on the principles and practice of surgery and on therapeutics (including *materia medica* and posology), public health and preventive medicine, medical zoology, pathology and bacteriology and applied physiology. He receives practical instruction in the wards and out-patients' department at the Adelaide Hospital and at the University on the subjects mentioned. He also has to attend a course in dentistry. In the fourth year he also is present at forty *post mortem* examinations and is required to examine pathological material from patients in the wards and complete three weeks' tutorial instruction in obstetrics at the Queen's Home. In the fifth year he again attends lectures on the principles and practice of medicine and of surgery and demonstrations in regional and surgical anatomy. He attends a course of lectures in obstetrics and gynæcology and spends three weeks in residence at the Queen's Home, attending women in their confinements. His clinical work continues throughout the year. In the Pathological Department he has to attend at forty *post mortem* examinations and to carry out certain practical work. He attends twelve times at the venereal diseases clinic and twelve times at the wards for patients suffering from infectious diseases. At the end of the fifth year, provided that he has completed all the work prescribed, he presents himself for the third examination. The subjects are clinical medicine and surgery, regional and surgical anatomy, operative surgery, therapeutics, pathology and bacteriology, preventive medicine and hygiene and medical zoology. The sixth year is spent in completing his general medical studies and in gaining an acquaintance of some of the special subjects. He works in the wards and out-patients' departments. He studies pædiatrics, ophthalmology, oto-rhino-laryngology, obstetrics and the administration of anæsthetics. He works in the gynæcological wards and also at the Adelaide Hospital for Children. Lectures on psychiatry, on forensic medicine and on clinical medicine and surgery have also to be attended. He is required to attend upon ten occasions the work of the dermatological department at the Adelaide Hospital and to attend a refresher course of three weeks' instruction in obstetrics at the Queen's Home. At the end of the year he sits for his final examination. The subjects include medicine and diseases of children, surgery, obstetrics, gynæcology, forensic medicine, psychological medicine, diseases of the eye, nose, throat and ear.

The fees, including attendance at the Adelaide Hospital and including the fees for examination, amount to approximately £300.

The degrees of doctor of medicine and master of surgery are open to graduates of at least three years' standing. The period may be shortened in special cases approved by the Council. A thesis must be submitted and, if this is deemed to be of sufficient merit, the degree may be conferred without further examination, otherwise a candidate for the degree of doctor of medicine must pass an examination in general medicine and in one of a prescribed set of subjects and a candidate for the degree of master of surgery must pass an examination in the principles and practice of surgery and in one of a prescribed set of subjects. The fee for the examination is fifteen guineas and for the degree ten guineas.

The following figures give an indication of the number of students in the Medical School, University of Adelaide.

In 1920 there were 42 first year students, in 1921 33, in 1922 47, in 1923 37, in 1924 8, in 1925 11, in 1926 17, in 1927 26, in 1928 23, in 1929 21.

The number of persons who have graduated in the respective years has been as follows: In 1909 7, in 1910 8, in 1911 15, in 1912 7, in 1913 10, in 1914 15, in 1915 13, in 1916 7, in 1917 15, in 1918 13, in 1920 8, in 1921 11, in 1922 16, in 1923 15, in 1924 19, in 1925 22, in 1926 23, in 1927 27, in 1928 13.

## Post-Graduate Education.

DURING the last few years the facilities for post-graduate education have been increased. Medical practitioners realize the necessity for continuous study and the wisdom of meeting their fellows in

post-graduate classes where they may receive instruction at the hands of teachers who are expert in the several branches of medical science, and where they may discuss their difficulties in the hope of receiving help. The improved organization of the courses has resulted in an increased demand for instruction.

### VICTORIA.

Victoria has undoubtedly shown the way in regard to the organization of post-graduate work. The Melbourne Permanent Committee for Post-Graduate Work was founded by the Victorian Branch of the British Medical Association in 1920. The committee is an autonomous body. It consists of a chairman and ten members, two of whom act as joint honorary secretaries. Three of these eleven persons are representative of the Victorian Branch, one represents the Faculty of Medicine of the University of Melbourne, one represents the Walter and Eliza Hall Institute of Research in Pathology and Medicine; the remaining six are representatives of the teaching hospitals.

An annual refresher post-graduate course is held every August. This course has been greatly appreciated and is attended by medical practitioners from all parts of the Commonwealth. It is made possible by the cooperation of the members of the honorary staffs of the teaching hospitals. The number of those who attended the 1928 course was thirty-two. The subjects chosen are comprehensive. Arrangements are generally made at the teaching hospitals for the accommodation of graduates attending the course. The fee for the course is as a rule three guineas. In addition to the annual refresher course, a special course of tuition is held annually in anatomy and pathology during the months October to March. The course comprises sixty lectures and demonstrations and is intended specially for those proceeding to the examination for the degree of master of surgery of the University of Melbourne. During November in each year there is a post-graduate course in obstetrics. This course is held at the Women's Hospital. Arrangements are made with the hospital authorities so that graduates attending the course may, if they wish, go into residence at the hospital. They are thus enabled to see the whole of the working of the institution.

In addition to arranging these regular courses, the committee has from time to time made arrangements for post-graduate lectures to be delivered by prominent teachers from overseas. Last year lectures were given by Professor F. R. Fraser, of Saint Bartholomew's Hospital, London, and in August, 1929, lectures were given by Professor Hugh Maclean, of Saint Thomas's Hospital. Special fees are paid for attendance at these lectures.

Arrangements have also been made by which lectures are delivered before the several subdivisions of the Victorian Branch of the British Medical Association. These lectures have also been extended to Tasmania. The lecturers act under the direction of the committee. The committee defrays the expenses of the lecturers and pays them a fee. The subdivision is responsible for the payment to the committee of the lecturer's fee.

### NEW SOUTH WALES.

The organization of post-graduate study and of post-graduate lectures in New South Wales has until recently been in the hands of the Organization and Science Committee of the New South Wales Branch of the British Medical Association. In February, 1929, a Post-Graduate Work Committee was created as an additional standing committee of the Council of the Branch "to organize and administer post-graduate work courses each year." It is hoped that this committee will be able to arrange for the regular holding of courses in the future. In April and May, 1929, a special course in obstetrics was held at the Women's Hospital and the Royal Hospital for Women, Paddington. Graduates were able to go into residence at the hospitals and to observe the working of the institutions. Lectures were given by the members of the honorary staffs.

Advantage has also been taken of the passing through Sydney of prominent medical practitioners to arrange lectures for members of the Branch. Last year by arrangement with the Melbourne Permanent Committee for Post-Graduate Work Professor Fraser gave two lectures in Sydney. A special fee was charged for these lectures.

In addition the Council of the Branch has made arrangements for the delivery from time to time of lectures known as British Medical Association lectures to members of local associations in the country. These lectures have been well attended and appreciated.

### SOUTH AUSTRALIA.

During the past twelve months no post-graduate courses have been held in South Australia. In September, 1928, the Council of the South Australian Branch of the British Medical Association authorized the formation of a permanent post-graduate committee. This committee consists of the President of the South Australian Branch of the British Medical Association, two representatives from the Faculty of Medicine of the University of Adelaide, two representatives from the honorary staff of the Adelaide Hospital, the chairman of the professional committee of the Queen's Home, two representatives from the Adelaide Children's Hospital, the Honorary Medical Secretary of the South Australian Branch of the British Medical Association and two joint honorary secretaries appointed by the Branch. The functions of the committee are: (i) to establish post-graduate courses which are to be held every year, if possible, such courses to include lectures and demonstrations at the various hospitals and the Medical School; (ii) to arrange for lectures to be given by visiting practitioners of eminence, particularly international visitors passing through Adelaide; (iii) to arrange facili-

ties at the Medical School and hospitals for country members of the Branch, whereby during visits to Adelaide they may be able to investigate methods which are of interest to them. The committee has arranged with Professor Hugh Maclean to give two lectures in August and for Sir Ewen Maclean to deliver a lecture after the third session of the Australasian Medical Congress (British Medical Association). It is hoped that during the coming year post-graduate courses will be held at the hospitals and at the Medical School.

### Queensland.

Post-graduate work in Queensland is in the hands of a post-graduate subcommittee. The members of this subcommittee are nominated by the Queensland Branch of the British Medical Association and by the honorary staffs of the metropolitan hospitals. On the recommendations of the subcommittee the Council of the Branch nominates lecturers, arranges for the payment of expenses and arranges time tables. Under the present arrangements a post-graduate course is held every year. At the time of the course the Joseph Bancroft Memorial Lecture is delivered. The lecture is delivered by a prominent practitioner from another State. The attendances at the courses have been satisfactory and it is hoped that in the future special courses may be arranged.

### Tasmania.

During recent years post-graduate lectures have been delivered from time to time in Launceston and in Hobart by prominent medical practitioners from other States. The Melbourne Permanent Committee for Post-Graduate Work has recently expressed its willingness to assist in arranging for the visits to Tasmania of lecturers from Melbourne. A committee of the Tasmanian Branch of the British Medical Association has been appointed with the following objects: (i) to arrange courses for post-graduate lectures from time to time; (ii) to approach any prominent medical men visiting Australia from other countries and to invite them to lecture to the profession in Tasmania; (iii) to approach any prominent medical men visiting Tasmania from other States and to invite them to lecture. At the time of the annual meeting of the Branch in February, 1929, lectures were delivered by Mr. Gordon Shaw and Dr. James Bell, of Melbourne. For these lectures a fee of one guinea was charged.

### Western Australia.

At the present time there are no post-graduate courses held in Western Australia.

## Statistics of the Medical Profession.

In the following paragraphs an attempts has been made to give accurate information in regard to the number of medical practitioners practising or entitled to practise in the several States. In many instances the information has been supplied by the Medical Board of the State in question. In some instances it has been necessary to obtain the figures from the register of medical practitioners.

### New South Wales.

On January 1, 1929, there were 3,010 medical practitioners on the medical register of New South Wales. Of these 2,151 were deemed to be resident within the State, 390 resided elsewhere in the Commonwealth, 39 resided in New Zealand, 19 resided in Great Britain and 39 in other parts of the world. During 1928 38 names were removed from the register, 34 were names of practitioners who had died during the year, and four were presumed to be dead, as the names could not be traced in any register.

The number of medical practitioners registered annually during the past ten years has been as follows: in 1919 80 names were added, in 1920 121, in 1921 111, in 1922 133, in 1923 197, in 1924 182, in 1925 153, in 1926 167, in 1927 90, in 1928 94.

### Victoria.

At the beginning of 1929 the number of medical practitioners whose names appeared on the medical register of Victoria, was 2,377 and of these 1,865 were resident within the State. During the year 1928 the names of 121 practitioners were removed from the register on account of death or for some other reason.

The number of medical practitioners registered annually during the past ten years has been as follows: in 1919 76, in 1920 100, in 1921 70, in 1922 103, in 1923 114, in 1924 132, in 1925 154, in 1926 84, in 1927 103, in 1928 100.

### Queensland.

On January 1, 1929, there were 561 registered medical practitioners resident in Queensland. The number of names removed from the register during 1928 was 49. These were removed because of the non-payment of the annual registration fee, departure from the State or death. Most of those names were removed on account of the non-payment of the registration fee, had left the State.

The number of medical practitioners on the register in 1920 was 371, in 1921 423, in 1922 414, in 1923 438, in 1924 461, in 1925 501, in 1926 560, in 1927 540, in 1928 546.

### South Australia.

At the beginning of 1929 there were 437 medical practitioners resident in South Australia whose names appeared on the medical register. The total number of those registered during the past ten years is 315. During 1928 nine names were added to the register. During 1928 the names of 51 medical practitioners were removed owing to death or for some other reason.

### Western Australia.

The number of registered medical practitioners resident in the State of Western Australia at the

beginning of 1929 was 280. During the year 1928 the names of two medical practitioners were removed on account of death.

The number of medical practitioners registered annually during the past ten years has been as follows: in 1919 14, in 1920 31, in 1921 16, in 1922 22, in 1923 20, in 1924 22, in 1925 27, in 1926 22, in 1927 30, in 1928 38.

### TASMANIA.

At the beginning of 1929 the names of 263 medical practitioners were on the register for the State of Tasmania. Of these 163 were resident within the State. Two names were removed from the register during 1928.

The number of medical practitioners registered annually during the past ten years has been as follows: in 1919 21, in 1920 23, in 1921 12, in 1922 17, in 1923 21, in 1924 15, in 1925 12, in 1926 19, in 1927 16, in 1928 13.

### GENERAL SURVEY.

From the above figures it will be gathered that there were 5,457 medical practitioners registered in the several States of the Commonwealth in January, 1929, and that these persons were resident in the State in which they were registered. The population of the Commonwealth for 1929 has been estimated as 6,486,741. At this rate there would be one medical practitioner for every 1,188 persons. In 1927 the number was 5,231. If these figures were accurate, the increase in two years would represent an increase of 4·32% or 2·16% *per annum*. The increase, however, was probably greater. It will be noted that while the total number of registrations in the course of ten years in South Australia was three hundred and fifteen, which is equivalent to about thirty-one each year, no less than fifty-one names were removed from the register in 1928. It would seem that this was a sort of adjustment and that the number of names in the 1927 register was too high. It is significant that no less than two hundred and eighty-two names were added to the six registers in 1928. While a few medical practitioners may have become registered in more than one State, it is certain that this source of error is not a large one. In the past the average increase of the medical profession in Australia has been about 4%. It is not improbable that the rate of increase has been almost as great during the past two years.

In New South Wales there would be one medical practitioner for every 1,165 persons. In Victoria the number would be one to 932, in Queensland one to 1,602, in South Australia one to 1,317, in Western Australia one to 1,401 and in Tasmania one to 1,324. These figures are, of course only approximate on account of the fact that the estimation was made with the estimated population for 1927, while the medical practitioners counted were those registered in the beginning of 1929. In computing the number of persons in a community to each medical practitioner consideration should be given to the number of specialists and surgeons and physicians who do not undertake the immediate care of patients. Allowance should also be made for those medical practitioners who are on the register, resident in the State and who have retired from practice.

## Medical Registration.

THERE is as yet no uniformity in regard to medical registration in the several States of the Commonwealth. Repeated attention has been drawn to the disabilities connected with the present state of affairs, but there are no indications of the willingness of the States to surrender their sovereign rights in this regard, although they have been approached by the Federal Government. Persons holding degrees or diplomas in medicine are required to register in each State in which they desire to practise. There is no medical act for the Federal Capital Territory and persons wishing to practise in the area must comply with the provisions of the New South Wales act.

### Fees for Registration.

In New South Wales no fee is required for registration.

In Victoria a fee of five guineas must be paid on application for registration and a further fee of five shillings is charged for the registration certificate.

In South Australia the fee may be paid in one of two ways. Either an annual fee of one guinea is paid or medical practitioners may pay the sum of five guineas either at the time of registration or subsequently as a commutation of all registration fees.

The fee for registration in Western Australia is ten guineas.

The registration fee in Tasmania is three guineas.

In Queensland the act provides that an annual registration fee shall be determined in January of each year and that this fee shall be paid by every medical practitioner. Any medical practitioner who fails to pay this fee, ceases to be a registered practitioner.

### Qualifications for Registration.

The persons entitled to registration are specified in the following paragraphs.

*New South Wales.*

(i) Graduates of Australian universities.

(ii) Graduates of universities in the United Kingdom.

(iii) Diplomates of the recognized medical corporate bodies in the United Kingdom entitled to registration in the United Kingdom.

(iv) Persons who are or have been appointed medical officers in His Majesty's sea or land services.

(v) Persons entitled to practise in a foreign country which has entered into reciprocal arrange-

ments with Australia in this regard, provided that they have passed through a course of study of not less than five years' duration.

(vi) Persons who have passed through a course of study of not less than five years' duration in a foreign country and are entitled to practise in that country and who pass an examination prescribed by the Senate of the University of Sydney.

No person who is a German or Austrian subject or who possesses a German or Austrian degree only, can be registered.

*Victoria.*

(i) Graduates of Australian universities.

(ii) Persons who have passed through a course of study of not less than five years' duration in a British university, college or in any foreign university, college or body recognized in that country and who possess a diploma or degree entitling them to practise in that country, provided that the same arrangements obtain in that country for graduates of the University of Melbourne.

(iii) One person holding the qualifications of the Boston Homœopathic University and College or of the New York Homœopathic Medical College and Hospital may be registered each year.

*Queensland.*

(i) Holders of a degree in medicine or surgery of any university in the Commonwealth of Australia or the Dominion of New Zealand which is legally authorized to grant such degree.

(ii) Persons who are registered or possess a qualification entitling them to be registered under the medical acts of the Parliament of the United Kingdom or any act amending or substituted for those acts or any of them.

(iii) Persons who have passed through a regular course of medical study of not less than five years' duration in a school of medicine, and who have received after due examination from some university, college or other body duly recognized for that purpose in the country to which such university or other body belongs, a diploma, degree or licence entitling them to practise medicine in that country.

The Act provides that the Board may refuse to register any person holding a qualification entitling him to practise in the country or state where such qualification was granted, if the Board is satisfied that under the laws, rules or usages of such country or state medical practitioners, duly qualified to practise in the United Kingdom of Great Britain and Ireland or in any part of His Majesty's Dominions, are not permitted to practise in such country or state.

Every medical practitioner on changing his place of abode is required to notify the fact by post to the Registrar. The Registrar may post a notice to any medical practitioner according to his address in the register inquiring whether he has changed his address or residence and if no answer is returned to such notice within six months after the posting thereof, the Board may erase the name of the practitioner from the register.

*South Australia.*

(i) Graduates of a university in Australia or New Zealand.

(ii) Persons registered or entitled to be registered in the United Kingdom.

(iii) Persons who have passed through a course of study of five years' duration in a foreign country, provided that the standard is not lower than that recognized in South Australia and who have received a degree or diploma and are entitled to be registered in that country, provided that equal rights are granted in that country to persons registered under the South Australian act.

*Western Australia.*

(i) Persons registered under *The Medical Ordinance* of 1869.

(ii) Persons who hold any one or more of the qualifications in the second schedule and whose diplomas, licences, certificates or other documents were obtained from some university, college or other body recognized for the purpose in the country to which such body belongs.

The person making application for registration must be of good fame and character and be entitled to practise under the qualification by virtue of which he applies to be so registered in the place where the same was granted.

The schedule to which reference is made, contains the following list: Fellow, member or licentiate of the Royal College of Physicians of London, of the Royal College of Physicians of Edinburgh, of the King and Queen's College of Physicians of Ireland, of the Royal College of Surgeons of England, of the Royal College of Surgeons of Edinburgh, of the Faculty of Physicians and Surgeons of Glasgow, of the Royal College of Surgeons of Ireland, licentiate of the Society of Apothecaries of London, of the Apothecaries' Hall, Dublin, doctor or bachelor of medicine or master or bachelor of surgery of some British or Colonial university.

(iii) Any legally qualified practitioner registered in the United Kingdom under any Act or Acts of the Parliament of the United Kingdom of Great Britain and Ireland. Medical officers duly appointed and confirmed of His Majesty's sea or land service. Any person who shall prove to the satisfaction of the Board that he has passed through a regular course of medical study of not less than three years' duration in a British or foreign school of medicine and has received after due examination from some British or foreign university, college, or body duly recognized for that purpose in the country to which such university, college, or other body may belong, a medical diploma or degree certifying to his ability to practise medicine or surgery, as the case may be.

*Tasmania.*

(i) Graduates of all British universities.

(ii) Persons entitled to be registered in the United Kingdom.

(iii) Persons who are medical officers in His Majesty's sea or land services.

(iv) Graduates of a medical college of Class "A" in one of the States of America, provided that they have passed through a course of study of four years' duration and have received a degree or diploma from that college and provided that they hold a certificate or licence entitling them to practise in one of the States of America.

## The Public Services.

### THE PUBLIC HEALTH SERVICES.

IN the Education Number of 1926, published in November of that year, special articles were published dealing with the departments of health in the Commonwealth. The greater part of the information in those articles may be relied upon as correct. In the following paragraphs we have given a *résumé* of the essential features of the several services.

#### COMMONWEALTH OF AUSTRALIA.

The headquarters of the Department of Health of the Commonwealth are situated at Canberra in the Federal Territory. The work of the department has grown considerably since its inception in 1921. It is carried out in divisions. The number of divisions has grown and the increase has in part at any rate been the result of the findings of the Royal Commission on Health. The Quarantine Division carries on the original work of the department. The Chief Quarantine Officer in each State has a staff under his control and in the lesser ports part-time quarantine officers have been appointed. The growth of the Laboratories Division continues. Since the opening of the Commonwealth Serum Laboratories at Royal Park in 1916, laboratories have been established at Rabaul, Bendigo, Toowoomba, Rockhampton, Lismore, Port Pirie, Kalgoorlie, Cairns and Launceston. The other divisions are the Industrial Hygiene Division, the Tropical Hygiene Division and those of Public Health Engineering, Epidemiology, Tuberculosis and Venereal Diseases, Maternal and Infant Welfare. In the Division of Tropical Hygiene there are a Director of the Division, the Director of the Australian Institute of Tropical Medicine, Townsville, three quarantine officers, four laboratory medical officers and some medical officers at the Townsville institute.

It is obvious that there is ample scope in the service for energetic men. They will have work of interest and importance and will have opportunity of advancement. The conditions of salary are set out in the accompanying table.

Mention must also be made of the establishment of a School of Hygiene and Tropical Medicine. This has been the outcome of the Royal Commission on Health. The Commission recommended the establishment of such schools and expressed the opinion that it would be expedient at first to attach one school to the University of Sydney. The undertaking will be financed partly by the Commonwealth Department of Health and partly by the University of Sydney. A director has been appointed and the building is in course of erection. Facilities will thus be provided for the training of medical officers in preventive medicine and in tropical hygiene and for the carrying out of research.

| Office. | Minimum. | Maximum. | Increments. |
|---|---|---|---|
| | £ | £ | £ |
| Divisional Director | 1,200 | 1,400 | 50 |
| Director, Institute of Tropical Medicine, Townsville | 1,000 | 1,250 | 50 |
| Chief Quarantine Officer | 900 | 1,100 | 50 |
| Assistant Director | 876 | 1,020 | 48 |
| Medical Officer (two positions in Division of Industrial Hygiene) | 780 | 852 | 36 |
| Medical Officer (others) | 708 | 852 | 36 |
| Senior Medical Officer | 876 | 1,020 | 48 |

#### NEW SOUTH WALES.

The public health service in New South Wales is controlled by the Board of Health and the President of this body is also Director-General of Public Health. The Board of Health administers the *Public Health Acts* and other legislative measures. The Director-General controls the medical departments of the public services of the State, the police medical work, the administration of the State hospitals and the care of the aborigines. The Microbiological Laboratory and the Government Analyst's branch are under his supervision. With the exception of the mental hospitals he has certain powers in regard to all the hospitals of the State.

Under the control of the Director-General of Public Health are the Senior Medical Officer, the Director of Maternal and Baby Welfare, two assistant medical officers, the Government Medical Officer and Police Surgeon, the second Government Medical Officer, the Principal Microbiologist, three assistant microbiologists, the Medical Officer of Industrial Hygiene and his two assistants, the Director of Tuberculosis, the Medical Officer of the Metropolitan District, the Medical Officer of Health of the Hunter River District, the Medical Superintendent of the Coast Hospital, a deputy medical superintendent and nine resident medical officers, the Medical Superintendent of the Waterfall Sanatorium and an assistant medical officer, the Medical Superintendent of the Lidcombe State Hospital, the Medical Superintendent of the Liverpool State Hospital and the medical officers at the institutions at Newington. The salaries of the officers range from £500 to £1,500 *per annum*. There has been some improvement in the remuneration of officers in the public services of New South Wales as a result of the efforts of the Public Medical Officers' Association.

Government Medical Officers are appointed at various country centres. These officers receive no salary, but are paid fees according to a fixed scale. Since the introduction of the *Workers' Compensation Act* in 1926 a chief medical referee and an assistant have been appointed.

#### VICTORIA.

The public health of Victoria is controlled by a Commission of Health, comprised of the Chief

Health Officer and six members appointed by the Governor-in-Council. The Commission of Health comes under the jurisdiction of the Minister of Public Health. For administrative purposes the State is divided into seven health areas and two of these are within the Municipality of Melbourne. Each health area is in the charge of a district health officer. The salary of a district health officer ranges from £700 to £850 *per annum*. Medical officers other than the district health officers are known as health officers. There is provision for five such officers. One acts as assistant to the district health officer for the central district, another acts as venereal diseases officer, another acts as infectious diseases and industrial hygiene officer. There are also a tuberculosis officer and an infant welfare officer. The health officers receive from £700 to £793 *per annum*. There is only one full-time municipal medical officer in the State; he is appointed by the Municipal Council of Melbourne and receives a salary of £1,100 *per annum*. All other medical officers appointed by municipal councils are part-time officers. They receive from £10 to £300 according to the duties which they are required to carry out. The conditions under which medical officers of the department work, have been materially improved as a result of the efforts of the Victorian Branch of the British Medical Association.

### QUEENSLAND.

According to the provisions of the *Health Act*, 1900, of Queensland, the Commissioner of Public Health is responsible to the Home Secretary for the administration of the act. At the present time the office of Commissioner is vacant and the head of the Department is the Acting Commissioner. In addition to the commissioner there is a deputy commissioner and health officer, a part-time tuberculosis medical officer and four part-time medical officers who are appointed to undertake the venereal diseases work of the department. The Commissioner of Public Health has complete charge of his department and he receives a salary of £950 *per annum*. In addition to acting as deputy of the Commissioner during the absence of the latter, the Health Officer assists the Commissioner and it is his duty to investigate outbreaks of infective disease and to take steps to combat them. He receives a salary of £850 *per annum*. The part-time medical officer attached to the Central Tuberculosis Bureau receives an honorarium of £200 *per annum*. He has to examine patients referred to the Bureau and has to determine whether they should be sent to the sanatorium at Dalby or to the Hospital for Chronic Diseases, the Diamantina. Patients suffering from venereal diseases are treated at the venereal disease clinics by the part-time medical officers. Female patients are required to attend the private surgeries of the medical officers; those in need of hospital treatment are sent to a lock hospital. The venereal disease clinics are held five times a week in the day time and six times a week at night time. Each medical officer receives an honorarium of £150 *per annum*. These medical officers are required to examine prostitutes every week. Branch offices are situated at Cairns, Cloncurry, Mackay, Townsville, Rockhampton, Charleville and Toowoomba. Arrangements are made at other centres than Brisbane for the hospital treatment of female patients suffering from venereal disease. The medical officers at the branch offices receive small honoraria for the work undertaken by them.

In the Education Number of last year we drew attention to the retrograde step taken by the Greater Brisbane Council in abolishing the office of City Health Officer. Emphatic protests have been made, but so far no steps have been taken to revive this important office. The size and the situation of Brisbane undoubtedly demand the attention of a whole-time medical officer. It is to be hoped that the Greater Brisbane Council will awaken to a sense of its responsibilities.

### SOUTH AUSTRALIA.

The control of public health in South Australia is vested in the Central Board of Health. The Board consists of five persons, the Chairman and four members, two of whom are legally qualified medical practitioners. Of the four members of the Board two are appointed by the Governor and two are elected, one being representative of the metropolitan and suburban authorities and the other of the country boards or local authorities. The Central Board is responsible for the administration of health laws in the sparsely populated areas. The appointment of a medical practitioner as officer of health of the local boards is compulsory "where practicable." The department does not always find it practicable to make such an appointment. A medical officer of health possesses all the powers of an inspector under the *Health Act*. On paper this arrangement appears satisfactory. Practically it will be found that opportunities for a career in the practice of preventive medicine as a departmental officer are very limited.

### WESTERN AUSTRALIA.

The public health administration of Western Australia has been prominently before the eyes of the whole Commonwealth and of other parts of the world on account of its pioneer steps in the control of venereal diseases. These steps were rendered possible by the fact that the *Health Act* of 1911 gave the complete control of matters relating to the public health into the hands of the Commissioner of Public Health and that the Commissioner had enough initiative, far-sightedness and determination to carry out his schemes. The Commissioner is responsible for the undertaking of measures to combat infective diseases, for the supervision of State hospitals and sanatoria and for all other matters connected with the preventive aspect of medicine as applied to the community. The Commissioner has as his assistants a medical officer of health, an

assistant inspector of hospitals and a bacteriologist. The last mentioned officer in addition to carrying out work for the department does bacteriological work for hospitals in the State other than the Perth Hospital. The salaries in the service range from £636 to £1,200 a year.

Reference will be made in another section to the fact that the school medical officers are attached to this department.

### TASMANIA.

For some years Tasmania has been without the services of a Director of Public Health. Although there is an assistant health officer, the report of the department is signed by the Secretary for Public Health who is not a medical practitioner. The present arrangement cannot be regarded as satisfactory. Until the whole position is reconsidered and a Director of Public Health is appointed, the hygienic affairs of Tasmania will not be put on a sound footing.

There is a whole-time medical officer for the city of Hobart. He is appointed by the municipality and carries out his work in accordance with the *Public Health Act*.

## School Medical Services.

UNDER ideal conditions of preventive medicine the health of the individual will be supervised from the earliest days right through life. Supervision will begin from the time of conception *in utero*. The regular inspection of school children is an important link in the chain. The years of school life are years of exposure to the exanthemata, they are years of rapid growth and development and they are years of susceptibility. It may thus be concluded that the medical practitioner who undertakes the work of a medical inspector of school children, is undertaking preventive medicine of the first importance. All medical practitioners are not suited temperamentally to work of this kind. It is sometimes held that medical school inspection is an easier life than that of a general practitioner, that the hours are regular, the salary sufficient and a pension assured. This is quite true. It would be quite wrong for anyone to undertake school inspection work if motives of this kind were the only incentive. Success could not possibly be expected, If, however, a man or a woman desires to train his or her powers of observation, to have opportunity of studying children from the psychological point of view, to have occasion to develope administrative ability and to meet fellow practitioners in an association which may be used to advantage by both parties, the career of a medical inspector in an education department may be recommended.

### NEW SOUTH WALES.

It is the policy of the School Medical Service of the Department of Education of New South Wales to visit each school once every three years and to make a complete examination of every child at every visit. Dental defects are treated in both metropolitan and country districts and an ophthalmic surgeon is employed to travel in the country districts.

The staff consists of the Principal Medical Officer (the office is at present vacant), eighteen medical officers and two ophthalmic surgeons. Of the medical officers eight are employed in the metropolitan area and ten in the country. There are eleven travelling dental clinics. The dental surgeon and his assistant in these clinics deal with country children. In the metropolitan area part-time dental officers are employed. It has been estimated that in each day's work a school medical officer examines about forty children and records his findings. In this way about 7,000 children are examined each year by each medical officer. Efforts are made to discover defects in the children and to have them corrected. It is in this way that cooperation between the school medical officer and the general practitioner is possible. The school medical officers also carry out sanitary inspections and occasionally give lectures on general hygiene to parents.

During recent years special efforts have been made to do something for mentally deficient children. The Special School at Glenfield is important in this regard. Here the children are taken into residence, their mental ages are determined and their treatment is arranged accordingly. The training is undertaken by teachers who are specially prepared for the work, and the children are made to a certain extent self-reliant. It is recognized that this work touches but the outskirts of what is required, but it is an important accessory to the medical inspection of school children.

One of the medical officers of the department acts as lecturer in hygiene at the Teachers' Training College and another attends the Children's Court in order that special attention may be paid to delinquents that come before it.

The salary received by medical officers on entrance to the Department is £528 rising to £630 *per annum* for men and £450 rising to £550 for women. When a medical officer is employed in the country, a travelling allowance of £180 *per annum* is made and all actual travelling expenses by rail, coach and tramway are, of course, paid. Senior officers who are men, receive £700 to £750 and women receive £600 *per annum*. Of the specialist officers men receive £750 to £850 and women receive £640 *per annum*. All candidates for admission to the department are expected to have had at least one year's hospital experience, preferably as a resident medical officer.

### VICTORIA.

Since medical inspection of school children was begun in Victoria in 1909, the original staff has been increased, so that at the present time it consists of a central group of four full-time officers (two men

and two women) and a country group of four officers (one man and three women). Some assistance in the work is given by four district medical officers attached to the Public Health Department. Each elementary school is visited every three years and at each visit every child is examined. High schools are revisited every two years. The dental staff consists of three dentists and four attendants in the metropolitan area and three dentists and three attendants in the country. In Bendigo, Ballarat and Geelong a dentist remains for four months in the year.

On visiting a school for the first time, the dental surgeon treats all children under eight years of age and leaves each one with a clean mouth. Next year the same school is revisited and the dental surgeon begins with the treatment of all who have entered school since his last visit and who are under eight years of age. He retreats all children who were treated on the previous visit. This is repeated each year and each child who begins treatment under eight years of age, is treated once a year until he is twelve years of age, when he is dentally fit; by this time all permanent teeth except the last molars have erupted. It is held that by this routine each child is left with regular and well spaced, healthy teeth and that with little further treatment the condition of his mouth should remain good for the greater part of his life.

In addition to the medical examination of school children the medical officers of the department are responsible for the examination of: (i) All teachers entering the department, (ii) all teachers applying for superannuation, (iii) all teachers on sick leave for a month or more. Lectures in hygiene are given by members of the central staff to university students taking the course for the diploma of education and to science students graduating in physiology and hygiene, as well as to teachers at the Teachers' College, Domestic Economy College and summer schools. The latest information available as to salaries is that in the year 1924-1925 the salaries of four medical officers, two dentists, three dental attendants and two school nurses amounted to approximately £5,000.

### QUEENSLAND.

The work of school medical inspection in Queensland is controlled by the Chief Medical Officer. He is assisted by one whole-time medical officer, an ophthalmic surgeon, eleven part-time medical inspectors, thirty-two "blight practitioners," eleven dentists and five nursing sisters. The Chief Medical Officer is adviser to the Minister for Public Instruction in regard to all matters relating to school health. On certain matters of policy the Chief Medical Officer confers with the Commissioner of Public Health. The medical officers of the department undertake the examination of candidates for admission to the Teachers' Training College.

On the dental side of the work great progress has been made. Ten dental surgeons are under the control of a Chief Dental Inspector, the work being of a high order.

Part-time medical inspectors receive a salary of £100 *per annum* with the exception of two who receive £50. The medical practitioners who treat blight in the western parts of the State, receive £50 *per annum*.

### SOUTH AUSTRALIA.

Since the appointment of a full staff for medical inspection of schools in South Australia in 1925 a high degree of efficiency has been attained. The present staff consists of the Principal Medical Officer, five medical officers (one man and four women), three dental surgeons, four school nurses, a psychologist, three dental assistants (two of whom are trained nurses) and a disinfecting officer, with the necessary clerical staff. The duties of the Principal Medical Officer are chiefly administrative and include the giving of lectures on school hygiene, the examination of women entrants to the Teachers' College, examination of teachers in school hygiene, the compilation of reports and so forth. The school medical officers have districts allotted to them and the work is so arranged that they all have a certain time in the metropolitan area. In this way they are enabled to keep in touch with one another and with the general work of the department. The psychologist works in collaboration with the medical officers and advice is given in regard to defective children.

The Principal Medical Officer receives from £600 to £700 *per annum* and the medical officers receive from £450 to £650 *per annum*. In company with all civil servants in the State, medical officers of the department are compelled to join the Government superannuation scheme. They are allowed to take up to eight units and this provides a pension of £208 *per annum*. The retiring age is sixty-five for women and seventy-five for men, but the former may retire at sixty and the latter at sixty-five years of age. Pension rights also obtain in regard to any officer of the department who is permanently incapacitated by illness.

### WESTERN AUSTRALIA.

Medical inspection in Western Australia is controlled by the Public Health Department. The arrangement is not very satisfactory and the work is severely handicapped by an inadequate staff. There is a part-time Senior Medical Officer and two full-time officers who are women. The Senior Medical Officer, Dr. Roberta Jull, is at present representing the women of Australia at the League of Nations. Of the full-time officers one devotes her time to the metropolitan area and the other works in the country. It is obviously impossible for two medical inspectors to do justice to the children in such an enormous area as Western Australia. Three full-time nurses are employed by the department and they assist the medical officers in the work of examining children. A start has been made in dental inspection of children and the Dental Hospital in Perth has been helpful in this direction.

TASMANIA.

Medical inspection of school children in Tasmania is carried out by two medical officers. One of these works in the northern and western districts of the island, the other confines her attention to the southern and eastern districts. Four nurses are employed by the department to assist the medical officers. The medical officers are assisted in regard to mentally defective children by the State Psychology Clinic. Special classes have been formed for these children. The remuneration of the medical officers starts at £375 *per annum* and rises by annual increments of £25 to £475. In addition to the medical officers the department employs four dental surgeons; two of these work in the cities and two in the country.

## The Mental Hospital Service.

NEW SOUTH WALES.

IN addition to the ten mental hospitals in New South Wales there are three licensed houses, four reception houses, one psychiatric clinic for voluntary patients and a pathological department. The number of available beds in the ten hospitals and the psychiatric clinic is 7,325. This number is not sufficient and the recommendations of the Inspector-General that they be increased have borne no fruit. The system of establishing out-patient clinics at various hospitals has been found satisfactory and patients with early signs of mental disease may receive attention at the Sydney Hospital, the Royal Prince Alfred Hospital, the Royal North Shore Hospital, the Parramatta District Hospital, the Newcastle General Hospital, the Goulburn and the Orange District Hospitals. At the Royal Prince Alfred and the Newcastle Hospitals beds are available for patients suffering from early mental disease.

The head of the mental hospital service is the Inspector-General of Mental Hospitals. He has complete control of all the institutions and of those engaged in them. He receives a salary of £1,400 a year. Medical superintendents of the first class (those in charge of such hospitals as Callan Park, Gladesville, Parramatta and Kenmore) receive a salary which starts at £971 4s. 4d. and rises to £1,071 4s. 4d., with a deduction of £124 for quarters, light, laundry and part furniture. Medical superintendents of the first class have a deputy and a staff of medical officers. At the smaller institutions there is a medical superintendent of the second class who has no deputy. Deputy medical superintendents and superintendents of the second class receive a salary starting at £847 4s. 4d. and ranging to £897 4s. 4d., with deduction of £100 for furnished quarters, fuel, light and laundry. A medical practitioner entering the service is appointed a junior medical officer at a salary of £463 4s. 4d., with a deduction of £100 for furnished quarters, fuel, light, laundry and service. At the end of twelve months he is either promoted to the position of medical officer or must leave the service. Medical officers receive £547 4s. 4d. a year, rising to £647 4s. 4d., with a deduction of £100 for furnished quarters, fuel, light, laundry and service. The duties of medical officers are those of a resident medical officer and they are required to attend the special course in psychiatry at the University of Sydney and to obtain the diploma in that subject. Promotion follows in accordance with length of service, but appointment to the position of senior medical officer and to the higher positions depends on the occurrence of vacancies. Senior medical officers receive a salary, starting at £697 4s. 4d. and rising to £797 4s. 4d., with the same deduction as that of medical officers. Medical officers are expected to carry out research work in the department in which they are engaged. The director of the pathological department receives a salary of £897 4s 4d. and is responsible for all the bacteriological, biochemical and pathological work of the mental hospitals.

At the conclusion of their period of probation medical officers are entitled to contribute to a superannuation fund. The rates of contribution vary with the age of the officer on appointment and the amount of pension depends on the rate of salary. Medical officers are given four days' privilege leave every month and are also allowed one month's annual leave for recreation. After fifteen years' service they are entitled to extended leave of three months and if the extended leave is taken after twenty years, its period is six months. If extended leave is taken later, it is calculated at the rate of six months for twenty years' service.

VICTORIA.

The care of the insane in Victoria is undertaken by the Lunacy Department under the administration of an Inspector-General. There are seven mental hospitals situated at Kew, Mont Park, Sunbury, Ararat, Beechworth, Ballarat and Royal Park. In connexion with the last named hospital there is a receiving house. Another receiving house is situated at Ballarat; it is independent of the mental hospital. There is a receiving ward at Bendigo. There are four licensed houses and three inebriate retreats. There are special wards for military patients at Bundoora and at Mont Park. At the Kew Hospital there is a separate institution for the care of mentally defective children, the majority is of the imbecile class. The number of persons certified as insane in Victoria is in the vicinity of 6,000. Under the voluntary boarder clauses of the *Lunacy Act* voluntary patients may be received into any receiving house or hospital.

The Inspector-General receives a salary of £1,500 *per annum*. There is a medical superintendent in charge of each of the mental hospitals. Medical superintendents receive a salary of £775 on appointment and by steady increments the amount rises to £925 with an annual deduction of £100 for rent, fuel, light, water, milk, vegetables and laundry ser-

vice. There are six senior medical officers and according to the Public Service Regulations they rank in Class B. They receive a salary, starting at £650 *per annum* and rising to £702, with deductions of £72 for rent, fuel, light, water, milk, vegetables and laundry service. There are eight junior medical officers in the service. The salary of a junior medical officer starts at £533 *per annum* and the maximum is £598. They receive partly furnished quarters, fuel, light, water, milk, vegetables and laundry service and for these a deduction of £60 is made. In certain instances they receive rations and in these circumstances a deduction of £14 is made. The pathologist is a whole time officer and has the status of a medical superintendent. He has charge of the laboratories at Kew, Royal Park and Mont Park and receives a travelling allowance. All the medical officers in the Department are entitled to come under the provisions of the *Superannuation Act* and they pay the statutory deductions. There is no provision for extended or long service leave and an annual holiday of only three weeks is allowed.

There are two half-time appointments for qualified medical practitioners to act as clinical assistants at the Royal Park institutions. They receive a salary at the rate of £200 *per annum* for the first six months of their engagement and £250 if they are appointed for a second period.

The medical superintendents at Royal Park and Kew and the pathologist are employed to give lectures to medical students at the University of Melbourne.

### QUEENSLAND.

There are three hospitals and one reception house in Queensland. The largest hospital is situated at Goodna, the other two are at Toowoomba and Ipswich and the reception house is at Townsville. There is accommodation for 3,073 patients. Patients with mental disease may be admitted to a special ward at the Brisbane General Hospital. The service is under the control of the Home Secretary's Department and is administered by the Inspector of Hospitals for the Insane. This officer also acts as medical superintendent of the hospital at Goodna and receives a salary ranging from £850 to £1,000 *per annum*. At Goodna a senior medical superintendent receives a salary of £575 to £750 *per annum* and a second medical superintendent receives from £500 to £650 a year. There is a third medical superintendent in receipt of a salary of £360 a year who is allowed to conduct private practice in the district. At the Willowburn Mental Hospital, Toowoomba, there is a medical superintendent receiving a salary ranging from £650 to £850 *per annum* and an assistant medical superintendent whose salary ranges from £500 to £650. At Ipswich the only medical officer, the medical superintendent, receives a salary of £600 to £800 *per annum*. All medical officers are provided with an unfurnished house, fuel, light, milk, garden produce and laundry service and each is entitled to six weeks' holiday leave every year. The reception house at Townsville is in the care of a nurse and is visited by a medical practitioner who is a part-time officer of the Department.

All medical officers may contribute to the superannuation fund set up under the provisions of the *Public Service Act*, 1922. According to this they are entitled to £100 during incapacity and to an annuity of £200 on retirement at a prescribed age. In the event of death a sum of £800 is paid to the next of kin. The incapacity allowance is payable after the officer has exhausted all the sick leave with pay and half pay for which the service makes him eligible.

### SOUTH AUSTRALIA.

In South Australia the control of institutions for persons suffering from mental disease is vested in a board consisting of three persons of whom the Inspector-General of Hospitals is chairman. According to the provisions of the *Mental Defectives' Act*, 1913, the Inspector-General of Hospitals is responsible for the general conduct of the Mental Hospital, Parkside, and for the manner in which the patients are treated. In addition to the Parkside Mental Hospital, patients are received at the Enfield Receiving House.

The Parkside Mental Hospital is under the care of the medical superintendent, who receives a salary of £975 *per annum*, with house, rations, fuel, light and laundry service. This officer is also superintendent of the Hospital for Criminal Defectives. He is entitled to six weeks' recreation leave each year and to sixteen days' sick leave on full pay. He also receives six months' leave on pay for every five years of service. There is a deputy superintendent who receives £725 a year, with house, rations, fuel, light and laundry service. His duties are those of a senior medical officer and he acts as deputy superintendent to the Hospital for Criminal Mental Defectives. He is entitled to three weeks' recreation leave and sixteen days' sick leave each year and also to six months' leave on pay for every five years' service. There is also a junior medical officer who receives £600 *per annum* with apartments, rations, fuel, light and laundry. He is entitled to the same leave as the deputy superintendent.

The Enfield Receiving House has a staff of two part-time medical officers who attend daily and when required by the matron. The average number of patients in residence is between eighteen and nineteen. Th superintendent rceives £360 a year and the deputy superintendent £290.

An arrangement has been made whereby two resident medical officers are appointed for interchange between the Adelaide Hospital and the Parkside Mental Hospital for a period of twelve months. Each serves for a period of six months at the two institutions. A salary of £100 a year is paid, with apartments, rations, fuel and light.

### WESTERN AUSTRALIA.

In Western Australia there is one public hospital for patients with mental disease. There are three

smaller institutions for the reception of ex-soldiers and private patients. There is provision at Claremont Hospital for over one thousand patients. The services are under the control of the Inspector-General of the Insane who is also medical superintendent of the Claremont Hospital. He is provided with a house and receives a salary starting at £960 and rising to £1,020 a year. The deputy medical superintendent is provided with a house and receives from £528 to £672. The assistant medical officer is provided with board, has certain allowances and receives a salary commencing at £456 and rising to £576. There is also a pathologist and bacteriologist who receives a salary ranging from £576 to £708. He also acts as relieving medical officer.

### TASMANIA.

There is one hospital for the insane in Tasmania, situated at New Norfolk. It is in the care of a medical superintendent who is directely responsible to the Minister controlling the department. He receives a salary of £707 a year with allowances valued at £93. There is an assistant medical officer who is paid £544 with allowances valued at £76. All who join the staff of the Mental Diseases Hospital before the age of thirty-two years, are obliged by the regulations of the service to contribute to the superannuation fund.

## The Defence Medical Services.

### THE ROYAL AUSTRALIAN NAVAL MEDICAL SERVICE.

THE objective of the Royal Australian Naval Medical Service is to watch the environment of the officers and men, to reduce the hours of incapacity of each person to a minimum and to devise means to improve the general health of the unit. The naval medical officer thus should have a knowledge of preventive medicine, he should be a competent practitioner and should have initiative and resource. He is required to enter the service at an early age in order that he may become accustomed to the peculiar requirements of the service. In order to provide a variety of clinical experience an endeavour is made to alternate periods of sea service with periods of shore service.

Candidates for entry to the medical branch of the Royal Australian Navy must be between the ages of twenty-one and twenty-eight. They must be sons of natural born British subjects. They must suffer from no mental or constitutional disease or weakness and must be prepared to engage for general service at home or abroad as required. A candidate must be a medical practitioner duly registered under the provisions of the *Medical Act* of one of the States of the Commonwealth or must hold qualifications entitling him to become so registered. The Dean of the Faculty of Medicine of the university in Australia in which the candidate was a student, may be called upon to testify to his character, conduct, professional ability or fitness. Evidence of a similar character may be required from candidates who have qualified in Great Britain or elsewhere. Candidates may be called upon to pass a competitive examination and no candidate is allowed to sit more than twice for such an examination.

During the first year of service the officer is on probation and is given the rank of Surgeon-Lieutenant. Confirmation in the rank of Surgeon-Lieutenant follows on the recommendation of the Director of Naval Medical Services. The period of service with the rank of Surgeon-Lieutenant before promotion is six years. In order to qualify for promotion to the rank of Surgeon-Lieutenant-Commander he must have served for two years at sea, be recommended for promotion by the Director of Naval Medical Services and obtain the approval of the Board. Should a Surgeon-Lieutenant reach his eighth year without having been promoted, he will be required to resign his commission unless he can show that this has been due to exceptional circumstances. A Surgeon-Lieutenant-Commander is due for promotion to the rank of Surgeon-Commander after six years' service with the rank of Surgeon-Lieutenant-Commander. He must have served for two years at sea since his previous promotion, he must have passed the qualifying examination, he must give evidence that he has not declined service except for reasons that were acceptable to the Naval Board, and he must have the recommendation for advancement of the Director of Naval Medical Services. A candidate is allowed to sit twice only for the qualifying examination. If he fails at the second attempt, his service will be terminated at the end of six years' seniority or before. The period of promotion may be shortened by obtaining certain special certificates. The period of promotion may also be shortened in each instance on account of conspicuous professional attainments or of distinguished naval service.

In the following table the rate of active pay and deferred pay for medical officers in the Royal Australian Navy is set forth.

| Time Served in Rank. | Active Pay *per diem.* s. d. | Deferred Pay *per diem.* s. d. |
|---|---|---|
| Surgeon Lieutenant— | | |
| "On Entry" | 28 0 | 5 0 |
| After Three Years | 32 0 | 5 9 |
| Surgeon-Lieutenant-Commander— | | |
| "On Promotion" | 38 0 | 6 6 |
| After Three Years | 43 0 | 7 0 |
| Surgeon-Commander— | | |
| "On Promotion" | 48 0 | 8 0 |
| After Three Years | 52 0 | 9 6 |
| After Six Years | 56 0 | 10 0 |
| After Nine Years | 60 0 | 10 0 |
| Surgeon-Captain— | | |
| "On Promotion" | 65 0 | 11 3 |
| After Three Years | 70 0 | 11 6 |
| After Six Years | 75 0 | 11 6 |
| After Nine Years | 80 0 | 11 6 |

Deferred pay is granted to an officer on retirement or resignation after he has completed ten years' service. In special circumstances deferred pay may be granted with the approval of the Naval Board to an officer who resigns before the com-

pletion of ten years' service. When an officer dies while serving in the Navy, the full amount of accumulated deferred pay is payable to his estate. Officers who are dismissed from the Navy for misconduct as defined in the *Naval Discipline Act*, forfeit all claim to deferred pay. Interest at the rate of 3½% is added to all accumulating deferred pay.

Medical officers serving in the Royal Australian Navy receive medical attendance in kind, subject to such regulations as may be approved by the Naval Board. When an officer first joins the service he is paid a uniform allowance of £50. Should the officer be discharged from the service within two years, except for invalidity, a proportionate part of the allowance will be refunded. Rations are supplied to officers. When on leave or detached service officers receive 3s. allowance *per diem*. Lodging allowance is paid to officers who are not provided with accommodation or quarters on shore at the following rates: For Surgeon-Lieutenants four shillings a day or £73 a year; for Surgeon-Lieutenant-Commanders five shillings and threepence a day or £95 16s. 3d. a year; for Surgeon-Commanders five shillings and sixpence a day or £100 7s. 6d. a year. A flag allowance is paid to the senior medical officer of the flagship of five shillings a day. The administrative allowance paid to the Director of Naval Medical Services if a Surgeon-Commander of under six years' seniority not on consolidated pay and to the assistant to the Director of Naval Medical Services if on sea-going pay amounts to three shillings a day or £54 15s. a year. Compensation is paid to medical officers on account of wounds or injuries received or diseases contracted while on duty.

When an officer has been in continuous service for a period of twenty years, he may be granted furlough for a period of not more than twelve months on half pay or not more than six months on full pay in addition to the ordinary annual leave. When an officer has served continuously for twenty years or more and has not been granted furlough leave, he may be paid six months' salary on retirement. Officers retiring after four years service are granted furlough in proportion to the length of service. The age for compulsory retirement is fifty-five years of age.

At the present time there is no provision in the Royal Australian Navy for the appointment of more than one Surgeon-Captain with a retiring age of fifty-five. Officers of lower rank must retire at fifty.

### THE AUSTRALIAN ARMY MEDICAL SERVICES.

THE Australian Army Medical Service cannot be regarded as offering a career to medical practitioners. The Army Medical Services consist of:

1. The Department of the Director-General, Medical Services, Army Headquarters.
2. Australian Army Medical Corps (permanent).
3. Australian Army Medical Corps (Citizen Forces).
4. Medical Officers of Training Areas.
5. Medical Officers of the Unattached List.
6. Australian Army Medical Corps Reserve.
7. Australian Army Nursing Service.

All the officers in the service are engaged in medical practice, public or private, but they have the satisfaction that they are doing a public duty in fitting themselves for war during peace.

### THE MEDICAL SERVICE OF THE ROYAL AUSTRALIAN AIR FORCE.

THE Medical Service of the Royal Australian Air Force consists of (i) the Director who is a permanent full-time officer, (ii) a full-time medical officer at the Flying Training School, Point Cook, (iii) a full-time medical officer at the Stores Depôt, Laverton, (iv) part-time medical officers at Richmond, New South Wales, Randwick, New South Wales, and Bowen, Queensland, (v) two Citizen Air Force medical officers in Victoria, (vi) a full time dental officer, Number 1 Training School, Point Cook. In addition to these there is a specially qualified medical officer in the capital city of each State who is appointed to conduct examinations of candidates for flying training.

The rates of pay for medical officers are as follows: A pilot officer receives £328 10s. *per annum* with deferred pay at the rate of £36 10s. *per annum*. A flying officer on appointment receives £419 15s. with deferred pay at the rate of £45 12s. 6d. *per annum*. A flying officer after two years in substantive rank receives £456 5s. with deferred pay at the rate of £54 15s. per annum. A flight lieutenant receives £529 5s. with deferred pay at the rate of £73 *per annum*. A squadron leader on appointment receives £620 10s. with deferred pay at the rate of £82 2s. 6d. A squadron leader after five years in substantive rank as such receives £657 with deferred pay at the rate of £91 5s. A wing commander receives on appointment £730 with deferred pay at the rate of £109 10s. *per annum*. In addition to the rates of active and deferred pay free quarters, fuel, light and rations are provided when available. Otherwise a daily allowance in lieu is paid.

## Membership of the British Medical Association.

THE British Medical Association was founded in 1832 for the purpose of promoting the medical and allied sciences and maintaining the honour and interests of the medical profession. In the year 1870 the total number of members of the British Medical Association in all parts of the Empire was 4,258. The members of the Branches in Australia at the present time number 4,239. In 1915 soon after this journal was founded the Branches of the British Medical Association in Australia comprised 2,455 members. There has thus been an increase in

the course of fourteen years of just over 70%. The figures for the several Branches are as follows:

| | |
|---|---|
| New South Wales Branch .. | 1,699 |
| Victorian Branch .. .. .. | 1,368 |
| Queensland Branch .. .. .. | 460 |
| South Australian Branch .. | 395 |
| Western Australian Branch .. | 234 |
| Tasmanian Branch .. .. .. | 83 |

The constitution of the British Medical Association is defined in the memorandum and articles of association. It is incorporated as a company licensed by the Board of Trade as a company not for profit and permitted to dispense with the word limited in its title. The units of the association are called Divisions. In the United Kingdom the Divisions are grouped together for certan administrative and scientific purposes into Branches; in Australia and some other dominions of the Empire the Branches are Branch-Divisions. The government of the British Medical Association is vested in the Representative Body. This body meets usually once a year and determines the policy of the Association. The Council has executive powers and carries out the work of the Association in the intervals between the meetings of the Representative Body. Certain matters are referred to standing committees appointed partly by the Representative Body and partly by the Council. The Representative Body is a democratic parliament with representation of every Division.

The British Medical Association has no power to trade, to collect funds by levy or to act in other ways like a trade union. It can carry out its objects in any way not forbidden by the articles of association, but is not empowered to do anything that is not consistent with the specified objects. The office of the British Medical Association is situated in the British Medical Association House, Tavistock Square, London. The chief officer is the Medical Secretary. *The British Medical Journal* is produced by an editor and two assistant editors. The business activities of the British Medical Association and of the journal are under the control of the Business Secretary and Financial Manager. All these officers are full-time officials; they are assisted by clerical staffs.

The overseas Branches have the powers, privileges and duties of Divisions and in addition can fix the subscription payable by members. They have the right to become incorporated under the companies acts of the State or Dominion in which they are situated. Unless advantage is taken of this power, the overseas Branches enjoy but a limited degree of autonomy and are subject to the will of the Representative Body on which they are represented. The New South Wales Branch, the Western Australian Branch and the Queensland Branch are corporate bodies and have all the powers, rights and duties of the British Medical Association itself.

Any registered medical practitioner is eligible for election to the British Medical Association and when elected becomes a member of the Branch in the area in which he resides. Part of the subscription paid to the Branches in Australia is remitted to London as subscription to the British Medical Association. The money so paid is used for general purposes of the Association, including the production of *The British Medical Journal.* Membership carries with it all the privileges of belonging to an organization that has as its first object the promotion of the medical and allied sciences, including the right to attend scientific meetings, lectures and clinical demonstrations and to take part in the deliberations. Members enjoy the advantages of the medico-political activities of the Branches and are subject to the rules governing ethical behaviour. Each member in Australia receives weekly a copy of *The British Medical Journal* and of THE MEDICAL JOURNAL OF AUSTRALIA for which the Branches pay an agreed sum per member. Members in Australasia have the further privilege of attending the Australasian Medical Congress (British Medical Association) provided that they pay the sum fixed for membership of this congress. A medical practitioner seeking election as a member of the British Medical Association must make application to the office of the Branch in the area in which he resides, and have the form signed by two members. In New South Wales the names of practitioners nominated for membership are published in this journal before election. This rule does not exist in any other Branch. The New South Wales Branch has an arrangement whereby medical students can be elected honorary associates without subscription. Honorary associates have the right to attend meetings of the Branch, but cannot speak or vote. THE MEDICAL JOURNAL OF AUSTRALIA is offered to honorary associates of any Branch at the reduced subscription rate of twelve shillings and sixpence a year.

The subscription to the several Branches is as follows:

| Branch. | Subscription. | | | Whole-time M.O. of Public Services. |
|---|---|---|---|---|
| | Metropolitan. | Country. | Junior. | |
| | £ s. d. | £ s. d. | £ s. d. | £ s. d. |
| New South Wales .. | 5 5 0 | 5 5 0 | 3 3 0 | 4 4 0 |
| Victorian .. | 4 16 0 | 4 0 0 | 2 12 6 | 3 3 0 |
| Queensland | 5 0 0 | 4 0 0 | 2 10 0 | |
| South Australian | 4 5 0 | 3 15 0 | 3 3 0 | |
| Western Australian | 4 4 0 | 3 3 0 | 2 2 0 | |
| Tasmanian | 4 0 0 | 4 0 0 | 4 0 0 | |

The subscription of members who have reached the age of seventy-five years in New South Wales is three guineas. The reduction in Victoria is restricted to medical officers on the permanent lists of the Defence Department. Members engaged in the Government medical services or in research or similar institutions may apply for a reduction of subscription which will be granted at the discretion of the Council.